

REPORT OF THE
STUDY COMMITTEE ON
PUBLIC HEALTH PRACTICE
IN CANADA



CANADIAN PUBLIC HEALTH ASSOCIATION
150 COLLEGE STREET, TORONTO 5

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*This study was made possible through the generous
assistance of the W. K. Kellogg Foundation
of Battle Creek, Michigan.*

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STUDY OF PUBLIC HEALTH PRACTICE

DURING and immediately after World War II there was a serious shortage of trained public health personnel in Canada. Many areas in Canada lacked the services of public health physicians and nurses, and in others the number of personnel available was so small and the services had to be spread out so thinly that they became ineffectual.

In 1946, the Executive Council of the Canadian Public Health Association undertook as its major project the study of this serious situation. The inadequacy of salaries paid to public health personnel was apparently one of the major causes of the existing shortage. After studying the salary situation, the Association published in 1946 the Report on Salaries and Qualifications of Public Health Personnel, outlining recommended salaries and qualifications for the various grades of public health personnel in Canada. The next obvious step was to study as objectively as possible the actual public health practices that were being carried out by public health personnel. As the shortage was most acute amongst physicians and public health nurses, it was decided to study the practices of these two groups. The Executive were of the opinion that studies of the actual work being done by physicians and nurses in official health agencies in Canada would be of value in assessing the factors, other than salary, which had produced the shortage of trained personnel in Canada.

The W. K. Kellogg Foundation of Battle Creek, Michigan, had been approached and had generously offered to supply the financial assistance necessary to carry out a Canada-wide study. A Study Committee on Public Health Practice was formed in 1947. Dr. John S. Kitching of Hamilton was elected chairman and the members of the committee were:—

Miss Isobel Black, Assistant Superintendent, Victorian Order of Nurses, Montreal. Miss Helen Carpenter, Lecturer, School of Nursing, University of Toronto. Miss F. H. M. Emory, Associate Director, School of Nursing, University of Toronto. Miss Helen G. McArthur, Director of Nursing Services, Canadian Red Cross Society, Toronto. Dr. James M. Mather, Director, Halton County Health Unit, Milton, Ontario. Dr. William Mosley, Director, East York-Leaside Health Unit, Toronto. Dr. D. S. Puffer, Assistant to the Chief Medical Officer of Health for Ontario. Miss Lyle Creelman, Canadian Public Health Association. Dr. J. H. Baillie, Canadian Public Health Association.

The field work was undertaken by Dr. J. H. Baillie of the Association and Miss Lyle Creelman who had been granted leave of absence from the Metropolitan Health Committee, Vancouver. Briefly, the problem given to this committee by the Executive was: to study the public health practice of the physician and the nurse in official health agencies in Canada and see what bearing these practices have on the recruitment and maintenance of public health staffs.

During the first few months of 1948 the Study Committee worked on various techniques of study and was divided into two sub-committees, one to study the public health practices of the public health physician and the other to study the practices of the public health nurse. Dr. Mosley was chairman of the public health physicians committee and Miss McArthur was chairman of the public health nursing committee. In addition, a provincial consultant committee was selected in each province from members of the Association and other workers in public health. The function of this consultant committee, in the first instance, was to discuss with the field team, when they visited that province, the policies of the provincial department and help the field team to select typical urban and rural areas which would be best suited for study.

It was realized that it would be impossible, with the time and money available to the Study Committee, to visit every health agency in Canada. It was decided that at least one urban and one rural area in each province should be visited. In the larger provinces more areas were studied. In addition to the nine provincial health departments then in existence, the following agencies were visited:—

Prince Edward Island. Nova Scotia—Northumberland Health Unit; Cape Breton Island Health Unit; City of Halifax. New Brunswick—Westmoreland Health District; Saint John and District Health District. Quebec—Montmagny Health Unit; Verchères Health Unit; City of Montreal; City of Quebec. Ontario—Halton County Health Unit; Oxford County Health Unit; City of Toronto; City of Hamilton. Manitoba—City of Winnipeg; Selkirk Health Unit. Saskatchewan—City of Regina; Health Region No. 1, Swift Current; Health Region No. 4, Moose Jaw. Alberta—City of Calgary; Red Deer Health Unit. British Columbia—Metropolitan Health Committee, Vancouver; Central Vancouver Island Health Unit; North Okanagan Health Unit.

While most of these agencies were studied intensively, some of them were visited primarily to obtain a comparison with a similar agency in the province, which had been studied more thoroughly.

As the Study Committee had confined the efforts of the field team to collecting information regarding practices of public health physicians and public health nurses, the provincial health departments were studied only in so far as the provincial policy affected the work of the physician and the nurse in the urban and rural health agencies.

The pattern followed in most provinces was as follows. The provincial department of health was visited and a meeting of the provincial consultant committee was called. The provincial policy regarding health, the administrative channels by which cities and rural health departments operated, the health problems which the committee felt were major in that province, the collection and availability of vital statistics, the policies in regard to venereal disease control, tuberculosis control, mental hygiene, environmental sanitation, child and maternal hygiene and public health nursing were discussed with the committee, particularly in relation to the work of the physician and the public health nurse at community level. Following this meeting, selected divisions of the provincial department were visited and then a week was spent studying the practice as carried out in one of the rural health areas of the province. At the end of this period another rural health department was visited for a short time in order to observe the differences, if any, in the practices of the two rural areas of that province. Following this, an urban centre was studied. In some of the larger urban centres all the aspects of the program were not studied as it was felt that some of the problems peculiar to the larger centres did not lend themselves to comparative study with practices as carried out in the smaller urban centres and in the rural health districts. Generally speaking, however, the programs in both the urban and rural centres lent themselves to objective comparison in regard to policies of public health practice.

Summary

The objective of the Study Committee on Public Health Practice has been to study and evaluate public health practice as carried out in Canada, to analyse those factors which relate to policy and procedure and, when indicated, to suggest remedial measures.

Public health as practised at the official agency level is not subject to exact definition. Through the years public health has assumed responsibility for services not defined or mentioned in legislation. Public health in this sense is evolutionary, and a static situation cannot and should not be anticipated.

Public Health Acts and Regulations of the various Provinces were designed originally to meet regional problems. The unfolding pattern of public health practice has, to a large degree, been influenced by the demands and resources, territorial and financial, of the areas concerned.

Provincial policy as noted in this report varies greatly throughout Canada. This naturally affects the services and participation of the local official agencies. It is recognized that a uniform national policy does not exist, but the fact remains that present public health services at the local level should be subject to careful scrutiny, and an attempt made to create some degree of uniformity in public health practice across Canada. Before this can be done, there must be agreement on and implementation of services which may be deemed desirable with rejection of certain undesirable features. It is suggested that, unless this is done, a consistent and sound administrative policy cannot be achieved at any level of government service. Policy develops with experience. There is a pressing need for more research and experiment at the local health agency level.

Each chapter on public health services in the report outlines certain recommendations which may be useful in this regard.

It is recognized that official health agencies by no means carry through complete public health programs. The various additions by non-official agencies and professional groups, of programs construed to be public health, at least in part, must be recognized. Each official agency should study the needs of the area, stimulate appreciation of the need for expansion of public health services, encourage participation in the local program by all responsible groups, and correlate these activities with the fundamental needs of the community, to prevent duplication of services.

The survey has also attempted to ascertain those factors which influence recruitment and maintenance of staff. Obvious factors are desire for public service, job satisfaction and reasonable salary schedules. As pointed out in the Report on Qualifications and Salaries of Public Health Personnel*, it is not so much the initial salary which tends to make the field less attractive to potential candidates as it is the confining limits of the usual salary range offered by official health agencies.

In far too many cases, official agency programs are purely routine as a result of provincial policy, local precedent, or both. The ambitious public health worker is unable to derive adequate job satisfaction from working in a groove, and he is apt to lose initiative or else leave for other agency positions which he feels will provide better scope for his abilities. For job satisfaction there must be freedom to explore, initiate, carry through and analyse projects. Such freedom is, of course, dependent, in great part, on the availability of sufficient money to provide facilities and staff to implement and supervise the desired program.

Educational qualifications and training standards for public health personnel have been raised. The full-time public health worker of the future should be a well trained and qualified person. To relieve such a member of purely routine work requires more appreciation and study of the role of the non-professional, clerical and voluntary worker in a well-rounded program.

It appears that public health may proceed in one of two directions. The first is toward centralization of authority at the Provincial level, with Provincial Departments of Health directing local programs through subsidy and supervision and with less area participation through official boards of health. The second is for Provincial Departments, by stimulation and subsidy, to encourage a more active participation on the part of the area itself, with increasing autonomy given

*Canadian Journal of Public Health, Vol. 40, 4: 143.

to the local authority. It is believed that the latter trend would be in the best interests of all concerned, where full-time services exist, satisfactory programs have been outlined and facilities and staff are adequate.

The Study Committee wishes to express its thanks to the Provincial and local Departments of Health and other agencies both in Canada and the United States, for assistance and suggestions given in this project, and for the many courtesies extended to Dr. Baillie and Miss Creelman.

ORGANIZATION OF PUBLIC HEALTH IN CANADA

The practice of public health in Canada is legally confined by the British North America Act to articles of the Public Health Act and other legislation in each province. The various Public Health Acts, while primarily enabling legislation, are administered in each province with somewhat different procedures. There are two main types of public health organization in Canada, the urban municipality which operates under the Public Health Act of the Province; and the county, multiple county or district health unit which operates under the same or similar Acts but usually in much closer co-operation with and supervision from, the central provincial department.

Urban Organization

The city or urban municipalities visited during the study were from east to west:—Halifax, N.S.; Saint John, N.B.; Quebec; Montreal, Que.; Hamilton; Toronto, Ont.; Winnipeg, Man.; Regina, Sask.; Calgary, Alta.; and Vancouver, B.C. The latter is the only metropolitan health department in Canada, although others are being planned. In general, it may be said of the cities of Canada studied that they operate their health departments with little aid from the provincial authorities. In most cases, there is some service given by the provincial Department of Health such as laboratory procedures, biological supplies, small grants for special clinics and some consultant service. With the exception of the Metropolitan Health Committee of Vancouver, which receives a grant each year from the Provincial Department of Health, the other cities do not receive a substantial grant. In the urban areas visited, the health departments do not receive a per caput grant of a nature similar to that given to the rural or county health units in most provinces. The provinces had not seen fit to subsidize urban health departments. Some of the city departments of health were not too anxious to receive grants from the provincial authorities because it was felt, rightly or wrongly, that such grants might imply control of their public health program.

With the advent of Federal grants-in-aid for health projects, the provincial authorities, through whom this money is dispensed, have in most instances found the cities willing to accept money for new projects in their department programs. This is leading to a better understanding and closer co-operation between departments. This does not imply that there has not been a cordial co-operative effort between the city health authorities in Canada and the provincial health authorities generally, but the co-operation which existed did not usually extend past the professional groups concerned.

In some provinces the provincial authorities and the authorities of the larger urban centres are attempting to work out a satisfactory scheme whereby the city department will benefit from the provincial per caput grants in a manner similar to rural areas. Several of the smaller cities in Canada which have become incorporated in a rural-urban type of health administration, receive provincial aid as do the rural county health units.

Rural Organization

In the rural and semi-rural areas of Canada, public health is administered with varying degrees of control from the central provincial authorities.

British Columbia

The program policy of the provincial health unit in British Columbia is primarily the policy of the Provincial Department of Health. A local board of health exists in each health unit area and consists of persons selected from the

governing bodies of the various municipalities and school districts. The main function of this board in actual practice is to approve the action taken by the medical officer of health in carrying out his duties. They have, to all intents and purposes, no power to spend the money allocated to that district, nor do they have the power to hire or fire the personnel of the unit. They may recommend action in these matters. All the health unit personnel are provincial employees and the operating expenses of the unit are paid by the provincial treasury. The individual tax-payer is assessed a per caput amount each year which is collected by the local tax agent. The province contributes approximately 70 per cent of the budget of the unit and the remaining 30 per cent is collected by taxation. In certain health units the board of health is active and attempts to assist the medical officer of health in his program and takes an intelligent interest in the health of the community. In other units, due to the fact that it is felt that it has no power to either draft policies or spend moneys, the board of health is less active.

Alberta

In Alberta, health unit administration is carried on somewhat differently than in British Columbia. Health unit areas are outlined by the province. The municipalities within the unit area, after voting to establish the unit, form a board of health consisting of at least one representative from each municipality. Larger municipalities may have more than one representative. In theory, this board is autonomous. The unit is financed by local taxes and a contribution from the provincial health department. The former meets 40 per cent of the total budget and the province, 60 per cent. However, the provincial contribution to the total budget is limited to a fixed amount designed to supply certain basic public health services to the community. If the local unit wishes to increase its existing services or supply new ones, it must provide the complete budget for these services by an increased local assessment.

The unit employees are generally recruited by the province but are employed by the local board of health. The health units are relatively small, with populations of approximately 16,000 and budgets of \$1.00 per caput. A few larger units containing urban centres have a correspondingly larger population and budget. The public health services are limited by the size of the staff and budget. Expansion of services is not encouraged by the limited participation of the provincial government. With the exception of a small account for transportation and office supplies, the money is handled for each unit through a central provincial treasurer. Due to the provincial program, the local authority and effort of a unit is handicapped. The unit staff members have none of the benefits of the provincial employees (pensions, etc.).

In the sparsely populated areas not covered by health units there is a service known as the district nursing service. The nurses in these districts are provincial employees. They attempt to provide not only public health nursing services, but bedside nursing on a visiting basis, first aid and emergency medical services.

Saskatchewan

In Saskatchewan, the rural health districts are large districts consisting, on the average, of 50,000 people and an area of 10,000 square miles. The staff members of the health regions are provincial employees. The public health program is primarily provincial, although there is a board of health consisting of members from each of the municipalities within the region which administers the public health program through the district medical officer and his staff. The budget for the health district is made up of two-thirds provincial grant and one-third local tax. This tax money is collected from the rate-payers of the region in such a manner that they know what proportion of their tax is being spent on the health services. The health district buildings are provincial buildings and

maintained by the government. In the area where the district board of health administers medical care as well as public health programs, the board is very active and has many powers. In the districts where the board of health administers only the public health program, it is not as interested.

Manitoba

In Manitoba, the Local Health Units do not operate under The Public Health Act of the Province, as does the City of Winnipeg Health Department, but rather under separate Health Services Act. In Manitoba, the health unit areas are smaller than in Saskatchewan, taking in approximately 1,000 square miles and a population of approximately 25,000 people. Health unit personnel are provincial employees and the budget money is obtained from local taxes (one-third) and from provincial government per caput grants (two-thirds). The health unit is administered by an advisory board constituted of members elected to represent the municipal governments within the unit area. This board has power to prepare a budget for the local expenditures and salaries, and to recommend changes in policy to the provincial government. In actual practice, the board has control of the expenditure of a small amount of money used for local up-keep and the province submits to it a pay-roll which the board approves. As in many provinces, the health unit is established by a petition from the various municipalities, and it may also be dissolved by a similar petition on approval from the Minister. This is a measure designed to give autonomy to boards of health. However, in practice, the local board's main function appears to be the approval of the work of the medical officer of health who carries out provincial policy. The local board of health, for instance, cannot or has not been able to raise salaries of its personnel to a level above that of the government salary schedules. Nor is it able, in most circumstances, to launch a project in a health unit which it feels is necessary unless this project is approved by the provincial department. In other words, the incentive for carrying out the work comes from the provincial department rather than from the people in the district.

Ontario

In the Province of Ontario the health unit set-up is somewhat different. The unit is established by a local by-law as in some of the western provinces. In Ontario the staff is employed locally and paid locally by the unit board of health. The program policy is local policy, agreed upon by the medical officer of health and the local board of health. In rural areas, the local community provides 50 per cent of the budget and the province matches this. The money is expended through the treasurer of the local board of health. The Provincial Department of Health exercises a certain amount of local control of the program by virtue of the fact that the health units must, under the Public Health Act, carry out certain duties which are theirs under the Act. However, these activities may be carried out in whatever manner is thought best by the local board of health. Minimum standards of qualifications for the full-time professional personnel in health units are set by provincial regulations. Health units must meet a minimum standard of salary but there is no maximum set by the province, and consequently the health unit board may pay its health officer in excess of the set minimum. As in other provinces, the Provincial Department exercises a type of control in the provision to health units of consultant advisory personnel in the medical, nursing and environmental sanitation fields. With the exception of new projects under the Federal grant, the local board of health may determine its own budget and the amount collected locally will be matched by the Provincial Government. No maximum on this type of matching grant has been set to date. With the exception of one health unit, in a western province where the board of health carried the responsibility of a medical-care program as well as public health, the interest and activity of the unit boards of health in Ontario was

generally greater than in other provinces, and appeared to lead to better community understanding of the public health program. This attitude appeared to result from the fact that the boards were directly responsible for the public health program, including the financing and the employment of personnel.

Quebec

In the Province of Quebec, the health units are primarily a provincial responsibility. The program is provincial, the personnel are employed and paid by the province and the budget is provided from direct local land taxes and general provincial funds. The local unit does not prepare a budget of its own. Local expenditures for travel and upkeep of the unit are covered by submitting expense accounts to the Provincial Department. There are no locally appointed boards of health.

New Brunswick

In the Province of New Brunswick, the health organization consists of multi-county health districts administered by a medical officer of health who is chairman of the board of health for each county within his district. It should be noted that the district medical health officer might have three boards of health within his district and he would act as chairman of each of the boards. At present there is a board of health for each of the fifteen counties (and in addition there is a board for the capital city of Fredericton) representing five health districts. The medical officers and nurses of the health districts are employed and paid by the Provincial Government. For the most part the local secretarial staff is employed by the board of health, and likewise the other employees of the board, *i.e.*, food inspectors, sanitary inspectors, etc. The administrative budget for each county board of health is derived primarily from the municipality, but the county board of health is required to provide salaries and accommodation for the health district offices. The activity of the county boards of health varies greatly and depends on the local interest; and it has been observed that as they do not have the power to spend the major portion of the district budget nor the power of hiring or dispensing with the services of the professional staff, many counties lack local interest in the program as it is presently constituted.

Nova Scotia

In the Province of Nova Scotia the administration of the health divisions is somewhat similar to that of New Brunswick in that each county within a health division may have its own local board of health and its own part-time medical officer of health. The local part-time medical officer of health has the same powers under the Public Health Act as the divisional medical officers of health. However, in questions of dispute, the divisional health officer has the final decision. The divisional personnel, including the physicians, nurses, qualified sanitary inspectors and secretaries, are all employed by the province. The budget source is provincial and the moneys are expended centrally by the submission of expense accounts. There is no multiple-county board of health and consequently the divisional or full-time public health staff is not administratively responsible to the local community. While this has merits, it also has the disadvantage of discouraging local interest in the program of the health division.

Prince Edward Island

Prince Edward Island may for the purposes of this study, be considered as a large health unit. The Chief Health Officer of the Province acts as the medical officer of health of Charlottetown and the health budget is obtained primarily from provincial funds. The personnel are all provincial employees. While part-time medical officers of health are appointed in certain areas, they are responsible for only a minor portion of the program.

Newfoundland

When this study was undertaken, Newfoundland was not a province of Canada and consequently the study was not carried out in that area. General observations in this report regarding public health practice in Canada, therefore, do not necessarily apply to Canada's newest province.

Other Areas

Areas of Canada administered by other than provincial governments were not included in the study.

PERSONNEL AND PERSONNEL POLICIES

Personnel

In all but six of the areas visited, the staff was considered to be numerically inadequate for the job the agency was doing. In all but the six areas there were budget vacancies, or the medical officer of health and his nursing supervisor believed the agency to be under-staffed. Eleven of the areas were regarded as under-staffed to a degree that limited the program drastically. If it is taken into consideration that a large number of nurses and other professional personnel employed in health departments have had no formal training in public health, the under-staffing situation is even worse.

Medical Personnel

There were 597 physicians employed full-time by the official health agencies in Canada at the time of the survey. Every province reported a shortage of public health physicians. The acuteness of this shortage varied from province to province, as did the shortage of public health nurses. Several provinces had plans for expanded rural health unit services but would not approve or initiate the services until a supply of nurses was assured. A record of the existing budget vacancies for public health physicians consequently would not reflect a true picture of the shortage of public health physicians as it appears to public health authorities planning the provision of services in the provinces.

With the exception of one city, all the medical officers of health of all the urban areas visited were physicians with post-graduate educational qualifications in public health. All the physicians of the ten rural units visited had the post-graduate qualification of a Diploma in Public Health or its equivalent. The possession of this qualification by medical officers of health has become a departmental policy in most of the provinces. The employment of medical officers of health on a full-time basis was the accepted policy wherever possible. The use of part-time medical officers of health was, with rare exceptions, confined to small municipalities. In one province the local medical officer of health of the smaller municipalities is retained when the area is incorporated in a health district or unit. In the other provinces, the full-time officer replaces all the part-time medical officers of health within the district when the health district or unit is formed.

Nursing Personnel

There were approximately 3,100 nurses employed in public health nursing positions in Canada. (This includes nurses in official and non-official public health agencies, industries, Red Cross and Schools of Nursing.)

In September 1948, the results of a questionnaire compiled by the Canadian Nurses Association showed an estimated shortage of 535 nurses in official and non-official public health agencies. In the majority of cases this represented the number of vacancies for which there was budget provision. With the expanding health programs since that date and with money for professional training now available through Federal grants, the present shortage is greater. In the agencies studied it was impossible for those in charge to give any reliable estimate of needs because, with provincial health surveys just being started, they could not make accurate predictions of future expansion.

Various authorities have considered that for a generalized public health nursing program (including bedside care) a ratio of one nurse for every 2,000 to 2,500 people should be the minimum. No province in Canada approaches that estimate. Two urban centres have one nurse to 2,500 population. In one of

these, however, there is such a multiplicity of agencies with resulting overlapping that efficiency of the combined services is impaired. It would be necessary to secure 1,600 more nurses for public health services in order to attain a national ratio of one nurse for every 2,500 people. In addition, 1,000 more nurses could be employed in industry. (See page 66.)

In the spring of 1949, approximately 250 nurses graduated from university schools and departments of nursing with preparation in public health nursing. This would meet little more than half the existing shortage in September 1948. The present facilities in university schools and departments of nursing could have accommodated 127 more students during 1948-49, and if further field training facilities were available this number could be increased.

According to the Weir Survey of Nursing Education in Canada (1), "The number of active registered public health nurses in Canada, as of January 1, 1930 was 1,521, including Victorian Order and Red Cross nurses. In other words, there was one active public health nurse for approximately each 6,500 population. Judging from reliable evidence submitted to the Survey, it would be in the economic as well as the health interests of the Canadian people if the above number of nurses were at least doubled within the next five years."

The 1949 number of 2,350 (3,100 less 750 in industry) is only about half as many more as the number in 1930. The ratio of one public health nurse to every 5,200 population (Table I) does not represent any great improvement over the 1930 ratio.

Table I
Ratio of Nurses Employed in Public Health to Population
Official and Non-Official Agencies
1949

Province	Nurses:Population	
	Province as a whole	Selected urban area
British Columbia.....	1:4,000	1:4,000
Alberta.....	1:7,500	1:4,500
Saskatchewan.....	1:9,500	1:4,000
Manitoba.....	1:6,000	1:3,500
Ontario.....	1:4,000	1:2,500
Quebec.....	1:5,500	1:2,500
New Brunswick.....	1:10,500	1:4,500
Nova Scotia.....	1:6,500	1:3,000
Prince Edward Island.....	1:11,500	*
Canada.....	1:5,200	

Table I indicates that nurses in public health agencies are not evenly distributed according to population. With one exception, the urban areas have a better ratio of nurses to population than has the province as a whole.

Of the nurses employed in official and non-official public health agencies, 38 per cent are not qualified in public health nursing. The non-official agencies which carry most of the bedside-care program in addition to their health education activities have a slightly higher percentage of qualified personnel than have the official agencies whose programs are supposedly almost entirely health educational in nature.

The range is from 94 per cent qualified in one province to only 22 per cent qualified in another. In the latter, the initial salary for public health nurses is low and there is no regular increment. Also there are limited facilities for preparation of public health nurses since the university which should prepare the

*No nurses with duties confined to urban areas.

majority of nurses is limited in field training facilities. This lack of areas for field training is largely due to the lack of a central division of public health nursing and organized supervisory and staff education programs for the nurses.

Non-Professional Personnel

Non-professional personnel of health agencies may be described under four headings:—

1. The trained practical nurse or certified nursing assistant.
2. The full-time lay worker.
3. The volunteer.
4. The clerk.

1. Trained practical nurse (Certified Nursing Assistant)

From information available, only one public health agency in Canada is employing trained practical nurses, namely the Toronto Branch of the Victorian Order of Nurses. In Ontario this worker is called the certified nursing assistant. This experiment in the use of a non-graduate nurse to give bedside nursing care was started in 1947 with the employment of two nursing assistants. The number has increased to five and more are being considered. The nursing assistant has about one year of theoretical and practical preparation conducted under the direction of the Provincial Department of Health. The workers are assigned to each of the five large district offices. They carry their own case load of chronic patients requiring bedside care. The first visit to the case is always made by the graduate nurse. If the care required is of the type for which the nursing assistant has been trained, the case may be given to her, but will remain the direct responsibility of the graduate nurse, who makes every fifth visit. The nursing assistant can give bedside care to an average of six cases daily. This makes it necessary to have between 50 and 60 suitable cases in order to keep her fully occupied. The agency is not yet prepared to make any statement as to the probable desirable ratio of nursing assistants to graduate nurses in this type of work. At present the smallest district in which a full-time nursing assistant is employed has a staff of twelve nurses. The personnel policies for this group are the same as for the graduate nurse. The salary range is lower.

An official agency did experiment with the use of the trained practical nurse but found that she could not be used for duties other than those which could be done by a clerk or a volunteer worker. In Canada it is general for the type of clinic in which practical nurses could be used to be conducted under auspices other than the public health agency. There are few clinics conducted by the health agency which are operating continuously, and they are usually child health conferences or chest x-ray clinics which do not have daily sessions. The volunteer or even the full-time lay worker, as discussed later, can be used for the non-nursing duties.

2. Full-time lay worker

Only one agency visited, namely the Toronto Department of Public Health, employs lay workers as assistants to the nurses. There are twelve of these workers, who are classified as "matrons". They were originally employed to relieve the nurses of the excessive nursing time taken by the control of pediculosis among the school children in certain areas of the city. The matron, under the supervision of the public health nurse, was responsible for the examination of children for this condition, carrying out the prescribed treatment procedure when indicated and the follow-up in the homes. As this problem has been brought under control, the matrons are frequently able to give the nurses assistance with other duties, such as clerical work, in the school and in the child health centres. The duties of the matron might overlap to some extent those of the volunteer, the difference being that the matron is on the agency staff and the volunteer is not.

In several of the urban areas visited considerable nursing time is spent on the control of pediculosis. The employment of full-time lay workers by these health agencies would save professional nursing time in this activity and others.

3. The volunteer

In the official agencies surveyed, four of nine urban areas and four of ten rural areas were not using volunteer service.

In areas where volunteers were used, there was considerable variation both in the amount of service used and the duties assigned.

In all areas in which there were volunteers, the greatest amount of service was given in child health centres. They frequently acted as hostess in the centre, directing the mother through the clinic routines, weighing the children, assisting with recording, supervising the pre-school group, and assisting with the set-up of the centre. In some cases a volunteer group sponsored a child health centre. In one urban agency, 3,395 hours of volunteer service were given during the year in child health centres.

The following information provided by another urban agency for the period of one year indicates the use of the volunteer in other ways:

14	volunteers	gave	376	hours	of	service	grading	audiometer	test	papers
36	"	"	2,519	"	"	"	"	"	"	in child health centres
3	"	"	9	"	"	"	"	"	"	as "baby sitters"
31	"	"	104	"	"	"	"	"	"	in clerical assistance
40	"	"	148	"	"	"	"	"	"	driving

In all, 124 volunteers gave 3,156 hours of service, most of which would otherwise have taken professional nursing time.

In mass x-ray surveys, volunteers are used extensively in some areas as members of publicity committees, as canvassers to make appointments, and as clerical workers.

In practice, the use of volunteers in the school health service program seems very limited and yet in this service there is frequently a considerable amount of routine clerical work. One nurse in an urban area remarked that she usually put aside about two mornings a month in each school to do such things as making out immunization certificates, dental cards, etc.

Visiting nurse agencies use volunteers extensively in the preparation of supplies and care of equipment and in such clerical work as the compilation of the monthly statistical report from the daily reports.

Very few agencies keep a record of the hours of service given by volunteers. Such a record can be used very effectively in publicity to obtain more workers. In addition to the actual cash value in terms of time given, the use of volunteers is a very effective method of helping to acquaint the public in general with the objectives, problems and accomplishments of the health agency.

Usually volunteers are secured through Women's Voluntary Services, Junior League, Red Cross and personal contacts. If obtained through an organized group, some orientation to volunteer work will have been given. It is important that some further introduction be given by the health agency. Following that, the nurse under whose supervision and direction the volunteer will work, is the one who will make the duties which can be assigned to volunteers popular or unpopular with the volunteer and other potential volunteers in the community.

A committee of the Canadian Public Health Association studied the use of volunteers in public health nursing programs. Their report is published in the Canadian Journal of Public Health, 1943, 34: 571. The suggestions made in relation to the selection, training, duties and supervision of volunteers are still valid.

4. The clerk

In two urban areas and two rural areas studied, the nursing division of the official agency did not have any definitely assigned clerical assistance. The nursing personnel could have the service of a clerk or clerks in other offices, but only when the clerk's regular duties were completed.

In some rural areas where nurses are working alone or in a two-nurse district where clerical assistance is not provided on a full-time basis, the nurse has the authority to secure part-time clerical services when required. This procedure might be followed to advantage more frequently. Many nurses, however, who are not accustomed to clerical assistance form the habit of doing these routines themselves, and find it very difficult to delegate such responsibilities to other workers.

The clerk in the average-sized health agency should be employed on the understanding that she will, on request, assume many duties which do not come into the sphere of ordinary office work; for example, the preparation of materials for sterilization, cleaning equipment and keeping it in order, setting up the immunization tray, etc.

The office clerk is one of the most important people in the public relations of the health agency. She is the one who makes the first contact over the telephone and frequently the first one to meet the person who comes to the office.

In almost all agencies visited it was definitely stated that there was not sufficient clerical assistance. It has been recommended that there be "one stenographer or clerk for each 2.6 full-time professional workers" (2).

Summary

1. There were 597 physicians employed in official health agencies in Canada at the time this survey was made.
2. There were approximately 3,100 nurses employed in public health services in Canada.
3. Eleven agencies visited were understaffed to a degree that limited their program drastically.
4. The number of nurses graduating from university schools and departments of nursing with preparation in public health nursing is far short of meeting the requirements.
5. For Canada as a whole, the ratio of public health nurses to population is 1:5,200. Over 1,500 more nurses would be required to make the ratio 1:2,500.
6. Of the nurses in public health nursing positions, 38 per cent have not had preparation in public health nursing.
7. In addition, there is a serious lack of qualified supervisors of public health nursing.
8. The trained practical nurse is being used by one visiting nurse association.
9. The full-time lay worker is being used by one official agency.
10. Volunteer service is not used across Canada as extensively as it might be to save professional time.
11. Clerks and stenographers are not employed in sufficient numbers by most agencies to avoid the wastage of professional time on activities not requiring professional training.

Recommendations

1. Through the professional training grants and other means available, agencies should give serious consideration to the urgent need for the preparation of public health nurses in supervision.

2. The nurse who is unqualified in public health should be employed only when there is a well-planned orientation program and continuous staff education. (This implies that there must be public health nursing supervision.)

3. Visiting nurse associations should use the practical nurse to the greatest extent possible while maintaining the efficiency of the service to the community.

4. Official health agencies should examine their nursing activities to determine the extent to which full-time lay workers might be employed to advantage to save nursing time, and when indicated, such workers should be employed.

5. Volunteer service should be extended by agencies not using volunteers to the fullest extent and should be initiated by agencies not yet using such service.

6. More clerical assistance should be provided. (In this respect, the use of dictaphones might be considered.)

References

1. Weir, G. M.: Survey of Nursing Education in Canada. The University of Toronto Press, Toronto, 1932, p. 49.
2. Proceedings of the National Conference on Local Health Units. American Public Health Association, 1946, p. 17.

PERSONNEL POLICIES

Salaries

In the Report on Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada, recommendations are made in relation to salaries and will not be repeated here. In the report the statement is made that "the recruitment and maintenance of staff is the major problem facing agencies today The recent graduate is usually content to accept a low salary during the postgraduate period and the first few years of service, but he or she will not even enter the field of public health when informed that the low starting salary is matched by an even more inadequate maximum salary, usually reached in a period of a few years. There is little or no monetary incentive to advancement for people already engaged in the practice of public health, and this is one of the main reasons why so many of our well-trained workers have left public health during the past few years. The small salary range, with increments usually confined to a period of five years or less, not only acts as a deterrent to recruitment but makes it very difficult to retain competent workers." (1)

Nursing Supervision

Good supervision is one of the most important factors in an effective public health nursing program. In selecting a position the relatively few public health nurses who each year are candidates for employment will, other conditions being equal, give preference to the agency where supervision is available.

Canada lacks qualified public health nursing supervision. Of nine urban areas studied, only three of the official agencies had nurses in charge of the nursing program who had had post-graduate preparation in supervision and administration. Of ten rural areas studied, only three had a staff of fewer than six nurses; no senior or supervising nurse had had advanced preparation. In three of these ten areas no nurse was named as senior, each staff nurse being individually responsible to the medical officer of health.

Only two university schools of nursing in Canada offer special preparation in supervision and these have not had a capacity enrollment.

Because of the shortage of qualified public health nursing personnel, agencies will, of necessity, continue to employ nurses unqualified in public health nursing. With the availability of bursaries for professional training, this procedure should be minimized. In view of the lack of supervision, whether qualified or unqualified,

it is to be regretted that some public health officials prefer to give employment to the registered nurse for a year before granting the training bursary. They consider that during this time they can determine whether the nurse is suitable for the public health field, and she, in turn, can decide whether it is the type of work she prefers. Public health nursing educators, from experience, believe there is more harm than good in this policy. Only when there is adequate* supervision and a well-planned orientation program (2), should such a policy be given any consideration.

Staff education programs are a part of good supervision. It was observed that where such programs were lacking, the nursing personnel (a) were not as up to date in their subject matter and methods of teaching, (b) tended more to a program of routines, (c) were less interested in their work, (d) did not recognize opportunities for the development of the program, (e) were little more than assistants to the doctor.

Seven provinces have at least one yearly meeting which all public health nurses attend. There is, however, quite a variation in the planning of the programs for these meetings. In two of the provinces there is no special program for the nursing personnel. The meetings may take the form of carefully planned institutes, lasting from three to four days and at which there are joint sessions as well as separate conferences for each group of public health workers, *e.g.*, doctors, nurses, sanitary inspectors, or the meeting may be for only one day, which, considering the distances to be travelled, hardly justifies the expense involved. Three provinces send regular news letters or bulletins to their staff. These, in addition to containing material in relation to administrative policies, are of distinct educational value.

A staff education program, to be effective, must be continuous and what is done on the agency level as apart from, or as a follow-up of the provincial meetings, is most important.

In one province all the nurses of the provincial staff are assigned to a geographic area and within that area a meeting is held on one Saturday of each month. At the first meeting in September a plan for the year is made and a topic selected for study. It will be a topic relating directly to public health nursing and one on which the nurses feel there is a need for further information. Every nurse participates and at the end of the year the material is prepared in printed form and sent to the provincial office. Material of general interest is selected and distributed to all nurses. This is an extra incentive to the educational program.

In one urban area a nurse on the consultant level is responsible for co-ordinating the staff education program of the official agency. The area is divided into districts. Each district group of nurses select their own topic for study and at the end of the year this material is sent to the central office for wider distribution.

In other agencies there were educational programs but none quite so well planned as those described above. Too frequently so much of the staff meeting time is used for administrative problems that there is little left for the educational program. In many agencies there is no plan to devote any time to staff education.

From observation it would seem that public health nursing conferences are rarely based on family case studies. If the objective is public health as a family health service, this type of approach for staff education merits consideration.

A supervising program has not reached its full development if it has not some plan for a written evaluation of each nurse.

*Adequate in relation to the qualifications of the supervisor and in relation to the number of staff nurses per supervisor which has been stated as—"A supervisor or director of nursing for each district; additional supervising nurses on the basis of one for each eight staff nurses or major fraction thereof". (2)

Of nine urban areas studied, three of the official agencies had written evaluations.

Of ten rural areas studied, none had written evaluations. One, however, had a form in preparation.

The Victorian Order of Nurses has a national policy which is followed in all branches. An annual evaluation is made of each nurse; in the larger branches by the supervisor in charge, and in the smaller branches by the regional supervisor.

A nursing manual is a necessity in an efficient nursing organization. The nurse can refer to it for agency policies, procedures, and the many details which are difficult to remember, especially when new to the agency. Visiting nurse associations have such manuals.

Of the official agencies studied, three in urban areas and five in rural areas did not have manuals. The five rural areas represented five provinces, and since, in the majority of cases, the manuals for the provincial staff are prepared in the provincial nursing office, this indicates a serious lack in other areas.

Uniforms

In only two of the urban areas visited did the nurses of the official agency wear uniforms. In both of these, the agency supplied the uniforms and made replacements.

For the official agency nurses under the supervision of the provincial health departments:—

- (a) in five provinces there is a recognized uniform.
 - (1) in one a yearly allowance is granted to the nurse,
 - (2) in one material is supplied every three years,
 - (3) in one material is supplied for initial uniforms only,
 - (4) in two no material is supplied or allowance granted.
- (b) in one province there is a recommended policy regarding uniforms which is being adopted by an increasing number of health units.
- (c) in three provinces there is no policy and uniforms are not worn.

The three visiting nurse associations each have an official uniform for which an allowance is given to the nurse.

Generally, with the exception of the official agencies of the larger urban areas, there are policies regarding uniforms for the majority of public health nurses. Almost without exception, the nurses who are in uniform like to wear it. They feel there are distinct advantages in educating the public to the fact that the wearer is a member of an agency which is interested in the health and welfare of all the community. The uniform has good publicity value. A bag is part of the uniform. Of the areas studied, both urban and rural, only the official agency of two cities did not supply their nurses with bags. In neither of these agencies was a uniform worn.

Recommendations

While many of the recommendations regarding general personnel policy that are outlined in the Report on Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada have received widespread acceptance, the following are repeated in this report as they have not been as generally implemented as some of the others and they are considered to be essential for good public health practice.

1. All professional or technical personnel employed by official health agencies should be employed on the understanding that they will receive, upon the recommendation of their employer, an annual increment up to a maximum salary, with competence in the performance of duties as the obviously sound basis for such recommendations. Maximum salaries must be comparable with those obtainable

in professional or technical jobs of similar responsibility in private enterprise in the same region.

2. All such employees of official health agencies should be allowed to participate in a superannuation or pension scheme, financed by contributions from employee and employer, or some equivalent method. It is desirable that these pension plans be made reciprocal and it is recommended that health agencies investigate the feasibility of reciprocal arrangements. It is recommended that after a minimum of twenty years' service provision be made to hold superannuation in abeyance for a person changing employment until the retirement age adopted by the particular scheme, after which payment would begin on the basis of contributions made.

3. Automobiles should be provided or car allowances be granted personnel whose duties require them to travel. Such allowances should not be regarded as forming part of the salary. The ownership of a car should not be a condition for employment. Where it is desirable for personnel to own cars and the agency does not provide a car, arrangements for financing the car should be made by the agency; this is most important for recruitment purposes.

4. Provision should be made in the budget of the health agency for professional training of personnel at postgraduate or refresher courses and attendance at scientific meetings.

5. When qualified, experienced personnel are newly employed, their starting salary should be at the level that their previous experience would indicate.

In addition it is recommended:—

6. In consultation with the nursing personnel, official public health agencies should adopt a policy in respect to uniforms for the public health nurses, and that an allowance for uniforms be granted to each nurse.

7. More attention should be given to all aspects of the staff education program for the personnel already employed.

References

1. Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada. Canadian Journal of Public Health, 1949, 40: 4.

2. Weir, George M.: Survey of Nursing Education in Canada. University of Toronto Press, Toronto, 1932, p.141.

RECORDING

One of the first practices noted was the manner in which the agency collected and recorded facts regarding the health of the community and the agency's daily staff activities.

Generally speaking, in the larger urban areas, vital statistics (births and deaths) were available to the medical officer of health. However, in five of the rural and semi-rural areas, vital statistics were not even available in time to be of use in the planning of a child and maternal health program. In these areas, either the health department did not have such a program or it received its information regarding births from other sources. In only nine of all the health agencies visited was an endeavour being made to utilize vital statistics in the planning of the future program of the community. This lack of planning is not entirely due to lack of interest, as some medical officers were interested but were totally unable, due to lack of staff and money, to do anything about planning. In approximately 50 per cent of the agencies visited, the health department had no active part in the collection, compilation or transmission of the vital statistics. In only one area visited was any attempt being made to study morbidity statistics.

In addition to vital statistics, agencies collect data regarding the amount of work the staff do, the number of children, parents, patients, schools visited, the number of lectures given, the number of pamphlets distributed, etc., most of which is used in a report form to try to convince the community, and particularly its elected representatives, that the agency is doing a satisfactory job. Unfortunately, the time required in some agencies to collect these data is far in excess of their value.

Data should only be collected routinely when they are of use in assessing the state of health of the community or to show the need for some service.

Recording in Public Health Nursing

Many of the records used by the health agency are completed by the public health nurse. It is assumed that a nurse at the end of a busy day does not want to sit down to record the time she entered Mrs. Jones' house, the time she left, and so on throughout her day's activities. And yet this is requested of many public health nurses across Canada. In spite of this, rarely is an analysis made of the collected information. A time analysis is useful but daily recording throughout the year should not be necessary.

Few agencies have records constructed to record the needs of and the service given to families. Most agencies have individual records for school children, individual records for infants, the tuberculosis case. Very frequently the basic family information is repeated on each. Some agencies are developing a family folder and have records which can be continuous throughout the life of the child and the adult.

It was probably with the idea of saving time that the very prevalent check-column records were constructed. On one infant and child health record there were columns in which for each visit of the mother to the child health centre or of the nurse to the home, the nurse was required to check the public health teaching done. The headings were—"breast feeding; establishing routines; diet; cod liver oil and orange juice; water; teeth; bath; hair; clothing and body temperature; sleep and rest; fresh air and sunshine; crying; habit formation and information slip." By the time all these columns were drawn on the record there was very little space, if any, left for the narrative recording which is so important.

The daily reports of nurses are usually not constructed with the idea of the family in mind. Very few asked the nurse to note the families visited. She has to make a note of the *number* of school visits and the *number* of non-communicable disease visits and the *number* of T.B. visits, the *number* of social welfare visits, the *number* of pre-school visits and so on. It is agreed that a service record is to assist in giving service to the individual and the family unit. In constructing records this should be kept in mind.

It may be necessary to collect figures on staff activity in order to impress the employing agency for the first year or two, but after that, data collected to justify the continued existence are an indication that the health agency has not established itself successfully in the community.

Recommendations

1. Each province should review the procedures regarding notification and registration of births and deaths and revise them where necessary so that the local health agency will receive, in time to be of use, the data required to plan and operate an efficient health service.

2. Each health agency should review critically the data it collects routinely with a view to eliminating all recording which is not analysed regularly and which is not directly related to the health of the public.

3. Data related to staff activity should be collected on a non-continuous sampling basis when it is necessary to analyse a part or all of the staff activity. Continuous routine recording of such data is not necessary nor efficient.

4. Sufficient clerical staff should be available to the professional staff so that professional time is not wasted on routine recording.

5. Individual health records of people in the community should be related to a family record where at all possible.

HOUSING OF AGENCIES

This subject has been included here because, although not strictly a practice, it is a factor which affects the conduct of the local program and the public attitude and acceptance of the program.

The housing facilities of the agencies visited varied according to the community itself. Of the twenty-four health agencies, only five were housed in facilities which could be considered good. Another twelve were classed as fair, and seven as poor. Four were situated in basements. Five departments in rural areas were in re-converted houses and the remainder were in various types of office buildings, either municipally owned or rented by the provincial department of health. Generally speaking, the larger municipalities had poor facilities. The rural health units had fair central offices, but poor branch or district facilities. In only five buildings was there sufficient space for the holding of child health conferences in the central office. With few exceptions, health departments are unattractive places to which the average mother would hesitate to take her children or herself for health services, and the average tax-payer would certainly not be impressed by the appearance of the housing of the health agency.

The generally poor housing facilities allocated to health agencies are another indication of the "poor relation" status of public health in the minds of governments and the public generally. If the public is to be attracted to the excellent services that public health can offer a community, surely the centres at which these services are offered should at least be clean, attractive, centrally located and large enough to permit the full functioning of a good program.

Recommendations

1. Whenever feasible, the health agency should be located in a community health centre. These centres should be designed to attract the public and provide facilities for the operation of a full public health program.

2. The use of second-rate, cheap facilities in the basements of churches and in other inaccessible, unattractive quarters as a means of providing the community with maternal and child health centres or other public health services is strongly condemned. This practice will never lead to widespread acceptance by the public of the services offered.

SCHOOL HEALTH SERVICES

School health services occupy a disproportionate amount of space in this study because it was felt that several of the major issues of public health practice are embodied in the present-day provision of these services.

In six urban areas, full-time medical officers were employed by the agency to do the school health services. In four others, part-time medical officers were employed by the health department in the same capacity. In ten of the fourteen rural and semi-rural areas the medical officers of health themselves were giving some type of school health service. In the four others, no service was being offered in the way of health appraisal of pupils. Where the service was offered, medical examinations were done for the early detection of defects and promotion of remedial action and, by having the parent present, an opportunity for health education was provided. While it may be said that the physicians with public health training who were observed doing school medical examinations with the parents present, took some advantage of this opportunity, generally speaking the medical examiner did not utilize the presence of the parent to advantage.

The medical examinations varied from hurried glances at nose and throat, with a stethoscope tucked under a child's shirt, to a fairly intensive examination. Where the facilities for examination were good, the examination was generally much better. Where there was no privacy for the examination and the number to be done was excessive, the routine examination had degenerated into a cursory affair.

The availability of treatment facilities, either private or public, for the correction of defects seemed to influence the type of examination. In seven of the agencies visited, the facilities for remedial work were considered to be good. In eight others, they were considered to be only fair, and in five others the facilities were classed as poor.

With few exceptions, more frequent and extensive services were offered in urban and semi-urban areas than in the rural districts. The notable exceptions were in two agencies where the medical officer had decided to give service mainly to those districts where general practitioners were not available. By a system of teacher-nurse screening, pupils were brought to a central rural school where the medical officer could give sufficient time to each pupil. While a few defects might be missed in children whom the nurse and teacher did not refer, a high percentage of the children with defects were examined. In most areas public health has developed a paradox: services where other medical services are available, and no public health services where other medical services are not available.

None of the agencies visited were obtaining from private physicians sufficient health examinations of school or pre-school children to supply the educational authorities with the information they desire. Not all agencies had attempted to obtain this co-operation. Some had tried and been unable to interest sufficient practitioners and parents to warrant a continued effort. Most were of the opinion that the practitioners were not interested, the parents did not want to pay for the examination and, therefore, to get the records the health agency must provide the service.

When services were offered to secondary schools, they were the same type as those in elementary schools. In a few cases, the school physician stated that the older pupils were encouraged to consult them when they had a health problem. In none of the areas studied was the secondary school program functioning as a consultant service to adolescents. This type of service exists in some schools in Canada, but was not seen in this survey.

Comment

In reviewing school health services, the objectives of the service should be kept in mind. These are two-fold: (a) the preventive medical or public health objectives which are to detect remediable defects early, control the spread of communicable disease by the use of antigens and environmental sanitation, and in general, to provide consultant service to the teaching staff on health problems; and (b) the educational objectives, which are to have sufficient data on the health of the pupils to form the basis for an integrated health teaching program and for the continuous supervision of the pupils' health. Each profession must accept its responsibility if these objectives are to be met.

In the areas studied, it did not seem that these objectives were being met. Most of the public health people who are assessing the pupils' health seemed unaware that this assessment should be done for the benefit of the teaching program as much as for the public health program. The main effort seemed to be to collect figures on the incidence of defects. It is true that in a few areas the teacher assumed that teaching health was as important as other subjects and that to do this properly and integrate it with other subjects, she must have data regarding the health status of her pupils and be capable of observing and reporting changes in this status. In most areas, however, the teacher thought her responsibility was to give health lessons, following the outline provided in the provincial school curriculum. This confused state of affairs is the result of many years of divided responsibility at the policy level, lack of co-operative effort at the local level, and lack of adequate training of the professional staffs of both the public health and teaching personnel.

For discussion, the following system is offered as meeting both the requirements of public health and education.

1. A physician examines each pupil in the presence of the parents prior to school entrance, records any defects and makes comments as to limitations in activity or special emphasis needed in regard to the pupil's health.
2. These examination records and comments are available to the public health nurse.
3. The comments on the records are available to each teacher and the data proceed with the pupil through his school life.
4. The public health nurse, with the co-operation of the teacher where necessary, convinces the parent of the need for carrying out the physician's instructions.
5. The teaching staff plan their program of health teaching, using as a guide the health records of the pupils.
6. The teaching staff, by continuous observation, note and record any changes in the health status of their pupils and refer to the public health nurse or the parent, depending upon the problem and the availability of medical advice, those problems which are felt to be beyond the capabilities of the teacher.
7. The teacher augments her observations and obtains teaching material by recording the height and weight of each pupil at least twice a year, and using the Snellen Chart to record visual acuity yearly. Auditory acuity could be listed at the same time by the whispered voice technique.
8. The public health nurse visits the school as frequently as required to provide a consultative service with the teacher on health problems and carries out a yearly inspection of the referred pupils.
9. Problems arising from the teachers' observations and the nurses' inspections are discussed with the parents. When a family physician is not available, the medical officer of health reviews the case and refers it to the treatment agency if such exists.

This type of school health service predisposes that the teaching and public health staffs are aware of their responsibilities and have had sufficient training to implement such a program.

Is not the family physician best qualified to examine and supply history and comments regarding health of the children under his care? It is suggested that if he is supplied with forms and is made aware of how the information will be used and knows that the pupils will be referred to him by the school health service and realizes that his opinion is necessary for course planning by the teacher, then he is more likely to co-operate. Is this not a good method of stirring up the interest of the private practitioner in preventive medicine? Is this not better for public health? Does not such a system put the responsibility where it belongs, with the parents and their own physician? Does this not do away with one of those routines that make for dissatisfaction amongst public health physicians?

In isolated rural areas where practitioners' services are not available, the system of screening by teacher and nurse may be instituted. In such areas it is not an efficient use of the medical officer's time for him to try to thoroughly examine all the school children. It takes a disproportionate part of his time for one of the services of public health. If he is to give only a cursory examination, then it is better to rely on teacher-nurse screening as it provides the teacher with teaching material and responsibility. With nurse screening, this produces a pupil assessment which is at least comparable to the general medical examination done in a routine hurried manner.

What value is derived from several other complete physical examinations done during the school life of the pupil? Some areas attempt to assess the pupil by medical examination in Grades I, III, V, VII, and XI. Does this provide the teacher with more up-to-date data on the pupils' health? Not if the teacher and the public health nurse have been giving continuous supervision. It does not help to increase the teacher's interest in the health of her pupils. It implies that the health agency is responsible for health supervision and the teacher loses interest. Does it help the pupil? Not if the remedial defects found at the examination have been corrected and there has been continued follow-up and supervision by the teacher and nurse as well as the family physician.

What is the logic behind the several so-called complete medical examinations given during the school life of the pupil? No satisfactory answer was obtained. School boards have learned to ask for these frequent assessments through habit, not through need, and it would seem that the public health authorities are to blame for the continued existence of the multiple medical examinations. Few of the health agencies studied had a working relationship with their local educational authorities. Few were studying school health services with the school teaching staff. It appeared that many health agencies were so busy giving a school service that they had no time to study the service to see if it was worth while or even necessary.

Public Health Nursing in Schools

1. Appendix F, page 76, based on information from some areas studied where a time analysis had been made during the Study, showed that, with the exception of one rural area, the single service receiving the most public health nursing time is the school health service. In all but one (A), this represents nursing time spent in the school building.

2. Appendix G, page 77, shows that a high proportion of the total home visits made by public health nurses are for the school service. The rate is higher in the urban areas than in the rural areas, being 23.5 in comparison to 17.1 for all the areas studied.

3. In five provinces the policy is for the rural schools to be visited once a year if possible. In three provinces, a visit is made once a month. In one province visits are only made by the nurse to prepare for the examination by the doctor.

4. In urban areas, the nurse usually visits on a regular basis. Depending on the size of the school, the frequency of these visits ranges from daily to weekly. It is usual for the nurse to stay at least half a day each visit. Where visits are made on this regular basis there is a much greater tendency on the part of the teachers to grant the request of any child who asks to see the nurse. Sometimes there is little reason for the visit, and screening by the teacher might reduce the number of unnecessary visits and provide the teacher with an opportunity for health teaching.

5. In the majority of areas the nurse gives a yearly inspection to all children not seen by the doctor. In two provinces, however, no individual inspections are made by the nurses.

6. In three urban areas, rapid classroom inspections are made by the nurses three times yearly. In a fourth, this is done twice yearly and in a fifth, it is done nearly every month.

7. In all areas studied but two (rural), the nurse does all the vision testing. In the majority of cases this is done yearly, but in six areas certain grades are selected.

8. In all areas studied but two, the nurse weighs and measures the children, although it was more general for the teacher to assist in this procedure than with the vision testing. In the two areas, if the teacher did not do the weighing and measuring it was not done. In two other areas, both rural, about one-half of the teachers were doing this procedure.

9. In the majority of cases, weights are recorded yearly and in one urban and one rural area visited, the nurse weighs the children three times a year. In only five areas is the weighing done on a selective basis.

10. It is usual for the nurse to discuss findings with the teacher after the doctor's examination or the nurse's inspection, but this discussion is usually only about the children with defects. Very seldom is there a planned conference when the other children in the class are discussed.

11. Some nurses give so-called "health talks", perhaps chiefly because there is such an item to be checked on the daily report. Usually these consist of a few words to the class following a health inspection and can hardly qualify, even under loose terminology, as a "health talk".

12. In the rural areas the visiting is chiefly confined to absentees who have been reported ill. This is not always so in the urban areas; frequently the nurse is presented with a list of all absentees without any effort having been made by school staff to discover the reason for absence.

13. In one school visited, in an urban centre, a special health record card had been designed for the use of the teacher and was being used very effectively. In the majority of areas the teachers make very little use of the school health records even when they are kept in the school and even when the school progress and health record are combined on one card.

14. In very few schools is there any systematic instruction given to the teachers regarding symptoms of ill health, of communicable disease, etc. Nurses seem very timid about attempting to instruct teachers.

15. In one area studied, the nurse was acting more or less in a consultant capacity to the teaching staff. The teachers screened the children for referral

to the nurse and/or doctor and otherwise took more responsibility for the health of her pupils. The nurse supplied up-to-date health literature in the form of pamphlets, posters, etc. Other nurses in the same area, although this was the policy of the health department, were not encouraging the teachers to take this responsibility.

16. In another rural area, where the nurse can rarely visit the school more than once a year, she attends the monthly meetings of the teachers of each of the thirteen districts and has planned an educational program in relation to the school services. The teacher has learned to inspect the children and to screen them for apparent defects. As the nurse's visits are infrequent, the teacher would consult the parents about major defects.

17. In only one of the urban areas visited did any of the schools have school health committees consisting of members of the school staff and of the health agency.

18. In many areas the nurses felt there was an excessive amount of clerical work in relation to school health services. In very few of the schools was clerical assistance provided even for the teaching staff. In one area some use had been made of volunteers for certain clerical procedures, such as recording immunizations on the individual record. Usually all this was done by the nurse.

19. In three large cities it is the policy for the nurse to visit every reported case of communicable disease at home. (The majority are school children.) In two of these cities, she must make a second home visit before the child is permitted to return to school.

20. Thirty-seven branches of the Victorian Order of Nurses do the school nursing in the communities they serve. These are communities in which the official agency, if any, has not yet assumed responsibility for school health service.

21. During the survey, interviews were held with personnel of one teacher-training institution in each of five provinces. As it was known that a study of the teaching of health in teacher-training institutions was under way by the Canadian Education Association, these interviews were to obtain general impressions from which definite conclusions should not be made.

Comments

Except in some rural areas it seemed to be the general opinion that the time spent on the school service is out of proportion to the other services. This unfortunate situation is not peculiar to Canada. A recent study made in the United States showed that 68.2 per cent of nursing time was spent in school services (including travel, conferences, home visiting and in the school.)

A review of the facts stated above in relation to nursing activities in the school indicates some items which are very time-consuming and which might possibly be reduced, if not entirely abolished. For example:—

- (a) Weighing all children yearly or more frequently.
- (b) Testing the vision of all children yearly.
- (c) Visiting of absentees for reasons other than illness.
- (d) Lack of screening on part of teacher for—
 1. referral of defects.
 2. routine referrals to nurse on regular visits.
- (e) Rapid classroom inspections at stated intervals.
- (f) Unnecessary clerical work.
- (g) Routine home visits to all cases of communicable diseases excluded from school.

Every health agency charged with any responsibility for school health services should examine the activities with three questions in mind:

What are the objectives of the school health service? (See page 27.)

What procedures are necessary and valuable to accomplish the objectives?

Who should carry out these procedures? ("Who" includes school personnel as well as health agency personnel.)

For example—is weighing not one method of interesting the child in good nutrition? Should not the teacher be able to spot defects in vision and hearing through her daily observation of the child? Is not the actual testing of vision by the use of the Snellen Chart a very practical application of a health lesson on vision? Who is responsible for health teaching?

Three observations of types of teaching are recorded—

1. The teacher was responsible for screening for defects and referral to the nurse. On a visit made with the teacher she mentioned two or three children who she thought had visual defects. She had changed the seating but would like the nurse to check with her. This was evidence of a genuine and practical interest in the health of the children.
2. In a rural school, visited to complete some immunizations, the children were studying by a correspondence course because of the lack of qualified teachers. The health lessons were discussed with the three Grade 8 children. They were keenly interested and explained that they had checked their own vision according to the chart which was printed in their book, had checked each other's hearing, and had taken an imprint of the arch of the foot according to instructions given. They told the nurse that their immunizations had been completed, and knew for which diseases protection was given. Health to them was a very practical subject and not a mere matter of learning factual material.
3. Conversely, in a rural school, the nurse, seated at the back of the room, was inspecting the children of the lower grades. This included weighing and vision testing. At the same time the teacher was taking a health lesson with a Grade 6 class. She was dictating questions and the children were writing the answers. Some questions were—What are the four parts of the heart? To what mechanical apparatus can the heart be compared? What is hæmophilia? What are the main arteries?

These remarks seem to be pointing to the possibility that health is not always being taught in the most effective manner. How is the teacher prepared to teach health? What instruction has she received in the teacher-training institution? The Canadian Education Association is conducting a survey of teacher-training programs in health. The findings will be published in the near future.

Of 17 teacher-training institutions (English), 7 have a continuous health service, 8 have part-time medical service, 4 have full-time nursing service, 4 have part-time nursing service, 9 have no medical or nursing service.

Only 5 replied in the affirmative to the question, "Is this service satisfactory in that it provides adequate protection for all students?"

Only 8 replied in the affirmative to the question, "Has your school an organized program of lectures or demonstration classes conducted by doctors, public health nurses or specially trained teachers?"

Only 4 of these teacher-training institutions have a public health nurse on the staff. Three of these combine health service and teaching duties. The fourth does the health teaching only. Not all are qualified teachers.

The preparation of the teacher for the teaching of health requires greater emphasis. Some feel that there should be a public health nurse under medical direction on the staff of the teacher-training institutions to serve in a dual capacity. One responsibility would be to provide health service to the students. In addition, she would serve as a consultant in the preparation of teachers for health teaching. Only if a public health nurse has additional preparation in the field of education should she accept responsibility for instruction concerning the method of teaching health.

Although definite conclusions should not be made on the basis of brief interviews, it would seem that the health content of the curricula and teaching methods of the various departments of education need study and revision. From superficial examination it would appear that the majority of educational authorities tend to emphasize theory and give too little guidance to the teacher in the teaching of practical health. Public health personnel are at fault in this respect. Few are aware of the content of the health curriculum and few make an effort to supply the teacher with material or suggestions which would help to apply the health instruction of every-day living.

Recommendations

(a) From observation it would seem that the school health services being given by the majority of health agencies in Canada should be critically reviewed from the point of view of—

- (i) the effectiveness of the service rendered to the child and its parents.
- (ii) the effective use of public health personnel or professional personnel employed on a part-time basis.
- (iii) supplying the teaching authorities with a pupil assessment and consultative service so that they may effectively teach health and supervise the health of their pupils.

(b) It would seem that until such time as the teaching of health and part of the supervision of health of the pupils is generally accepted as a responsibility by the teaching profession, public health will not succeed in establishing either an adequate health referral system in schools or a basic knowledge of health in the minds of the pupils.

(c) In furtherance of this, it would seem logical that an intensive study should be made of the facilities available and the content of the health curricula being used by the various teacher-training institutions in Canada.

Until such time as these first three are implemented, a reasonable approach from the point of view of the health agency staff might be to undertake, as has been done in a few areas, a program of teacher education by conferences and demonstrations between the teacher, nurse and medical officer of health. These could best be started at regional teacher conferences.

(d) It would seem that there are good reasons why a public health agency should undertake to determine, through a medical examination, the health defects of the children of the community when they become members of the school population. From then on they should be examined medically only when referred by the teacher to the nurse and from the nurse to the physician.

MATERNAL AND CHILD HEALTH

For the purpose of this report, maternal and child health services are composed of pre-natal, post-natal, infant and pre-school health supervision.

Pre-natal services

In only one of the agencies visited were pre-natal medical services offered. In some of the large urban areas, hospital out-patient pre-natal services were given, but health departments themselves, with the one exception, did not offer a medical pre-natal service. A pre-natal nursing program was provided by several agencies but usually extended to only a relatively small number of the expectant mothers in the community (Table II). Most health departments were of the opinion that the extension of their program to include pre-natal classes and pre-natal supervision would be construed by the private physician as interfering with his practice. Most, however, agreed that pre-natal classes or group teaching by the public health nurse would be a good service to offer.

Table II

Pre-natal nursing supervision in urban areas visited for which data are available.

Urban Area	Number pre-natal cases per 100 births, under public health nursing supervision
1	14
2	14
3	3
4	7
5	33
6	25
7	25

Records from rural areas visited were not available, but from observation and discussion it is doubted if the situation in the rural areas is any better; the impression is that the figures would be even lower.

Pre-natal classes

- (a) Of the official agencies visited only one conducted pre-natal classes.
- (b) In addition, in one city, the official agency was a partner in a joint project in pre-natal education sponsored by the welfare council. Through the efforts of this group pre-natal classes were reaching relatively more mothers than in any other area visited.
- (c) Of a total of 105 branches of the Victorian Order of Nurses, 22 conduct pre-natal classes.

Post-natal, infant and pre-school services

Home visiting as part of the child health program was offered in all except the occasional health unit where staff was not available to give this service. The child health centres operated by the health agencies visited, varied from clinics for the weighing and measuring of babies only, to child health centres with a paediatrician in attendance and nurse conferencing. As might be expected, the well-conducted child health centre, providing good nursing conferences on an

appointment basis, with volunteer help and privacy for conferencing and medical examination, attracted the largest numbers. This was not considered by the community to be a charitable service. In other areas where the facilities were poor with no privacy, and the clinics not well organized, there seemed to be a tendency for such clinics to be considered charity services and they were attended in the main by families in the low-income group.

Of the twenty-four agencies visited, eight utilized full-time public health physicians in some capacity in the child health centres. In five, the physician attended most of the sessions, and in the other three, the centre was visited once or twice a year. Part-time physician services were available in thirteen of the areas and eleven agencies did not provide a medical officer at the child health conference.

Post-natal nursing service

- (a) This is given in the homes more extensively by the visiting nurse associations than by the official agency.
- (b) With earlier discharge of patients from hospitals, visiting nurse associations are being asked to give an increasing number of demonstration baths.
- (c) In most areas visited where there are no visiting nurse associations post-natal nursing service is relatively undeveloped.

Infant and pre-school nursing services

- (a) *Home visits*
Appendix G, page 77, shows that of the total home visits of official agencies in areas studied:
 1. In urban areas 40 per cent are to infants and pre-school children.
 2. In rural areas 32 per cent are to infants and pre-school children.
- (b) *Child health centres*
Pre-school children attend child health centre sessions but in only one area visited is there a plan for play facilities for the pre-school child. More frequently they accompany the mother and not much attention is given to them.

Facilities

Child health centre sessions are usually held wherever free or low-cost accommodation can be secured—church halls, legion halls, schools, etc. Equipment must be set up and taken down before and after each session. In only one area visited was the space originally designed for use as a child health centre.

In most, but not all cases, there is a separate room for the doctor. In very few is there adequate space for privacy for the nurse's conference.

Frequently the centres are unattractive and the opportunity for use of health educational material is neglected.

Use of volunteers

- (a) In rural areas, 4 of 10 did not use volunteers.
- (b) In urban areas, 4 of 9 did not use volunteers.
- (c) Where used, they acted as hostesses, weighed babies, pulled records, recorded weights and other routine data, and assisted with set-up of centre.

Conferencing by nurses

- (a) In all but one rural and one urban area, the child health centre was arranged so that the nurse had a desk or table to which the mother came to discuss the progress of the child. In the two areas excepted, there was no such conference—the nurses did little more than what might have been done by volunteers.
- (b) There is considerable variation in the amount of advice the nurse is permitted to give.
 1. In the rural areas where no doctor is in attendance, she uses her judgment. If she is reasonably sure the mother does not attend a private physician, she may change a formula. She will, in all cases, suggest an addition to a formula if indicated and will advise when new foods are to be added to the diet.
 2. In areas where a doctor is in attendance,
 - (a) in some the nurse will suggest the addition of new foods, will add to the formula, but not change the formula.
 - (b) in some the addition of new foods may be discussed with the mother, but all cases must be referred to the doctor in attendance.
- (c) The mothers ask many questions and the nurse frequently finds that she is handicapped by her lack of knowledge of the physical and mental development of the normal child. The following information is of interest in relation to the general questions asked.

This information was supplied by 35 public health nurses from three cities. They were requested to write, on a special form, the questions asked by mothers during the conference between mother and nurse in the child health centre. The questions asked by 280 mothers of infants (under 1 year) and 52 mothers of pre-school children (1 to 5 years) were classified as to those relating to nutrition, to physical development, mental and emotional development and general health. Table III shows the distribution of the questions.

Table III

	Infant	Pre-school
Number of mothers interviewed.....	280	52
Questions relating to:		
Nutrition.....	237 (49%)	23 (28%)
Physical development.....	107 (22%)	17 (21%)
Mental and emotional development...	36 (7%)	25 (31%)
General health.....	107 (22%)	16 (20%)

From the table it is noted that:

- (a) Questions relating to nutrition were nearly half of the total in the infant group, and over one-quarter in the pre-school group.
- (b) Questions relating to mental and emotional development:
 1. were relatively more numerous in the pre-school group than in the infant group.
 2. were more numerous in the pre-school group than the questions relating to any other aspect.

Comment

Whether the health department should supply physician services at a child health conference is dependent to some extent on the availability of private practitioner services in the community. It is desirable that the official health agency should have a record in the early part of a child's life of a complete physical examination so that remediable defects may be corrected and a life record

started. In areas where private physicians are available, such examinations would preferably be done by him and he should then refer the child to the child health centre for nursing supervision until such time as some problem arises which the nursing personnel are unable to handle. In the large urban areas where the general practitioner does not wish to look after the children of his patients, the health department may provide a paediatrician for the initial examination. However, other than for the training of paediatricians, it is not understood how a health department can justify using the services of a paediatrician to see a well child every two or three weeks in the first few months of its life and every two months later on. On the visits following the first examination, most of the information and suggestions given to the mother by the attending physician might well be given by the public health nurse. In areas where private practitioner services are not available, the health department may feel obliged to provide a continuous medical service, not just an initial examination. This might be done by having the nurse refer problems to the child health centre on the day when the medical officer is in attendance. In other words, he would not attend all conferences, but would be available for consultation. This type of service is dependent upon the public health nurses having an adequate post-graduate and undergraduate training in the normal growth and development of the infant.

Nursing in Child Health Services

In this country, public health nursing originated with the school service and in a few communities this is still the only public health nursing service. It was considered that the easiest entry into the home was through the school. But such a viewpoint is no longer valid. In most communities and homes, the public health nurse is welcomed. As health workers we have not moved as rapidly as the public. We continue to allow the school service to consume a large proportion of time and we have not yet developed a true family health service. The nurse continues to make "defect visits", "absentee visits", "immunization visits", etc., instead of considering the family as a unit. This tendency is encouraged by the type of daily report which she is required to complete.

The maternal and child health program is the beginning of the family service. A study of the facts presented above reveals that our programs of pre-natal nursing supervision are very weak. The figures on the urban list in Table II, page 33, are sufficiently representative of the service across Canada. In a study made by the American Public Health Association (1), the median figures for pre-natal nursing supervision were 18 per cent. The urban area studied in Canada showing the highest number with pre-natal nursing supervision has a unique program. A Pre-natal Education Committee of the Welfare Council of Toronto (2) has, during the past four years, organized pre-natal classes throughout the city. The new registrations at these classes in 1947 were 877. The nursing personnel of the official health agency and the visiting nurse associations share the teaching at the ten centres. The nursing supervision in the home is shared by the official health department and the two visiting nurse associations. Thus, all public health nurses have this added field of interest. Where there is a visiting nurse agency it is usual for the official agency to refer all pre-natal cases for supervision. This limits the generalization of the nursing service of the official agency. Thus, in Toronto, the nurses of one of the visiting nurse associations have an opportunity to assist the child health centres sponsored by the official agency, thus broadening the field of interest.

An instance is recalled where a nurse in a rural area was asked about the pre-natal program. She replied that she did not have any program, that the mothers were really very good in that area as they all went to their own doctors. Are public health nurses themselves convinced of the importance of nursing

supervision during the pre-natal period? Have public health agencies convinced the doctors, starting with the medical officer of health, that the nurse has a service to offer which will not replace, but rather supplement, the advice the doctors give to the expectant mother?

Mothers are most receptive to teaching when they come home from hospital with a new baby. Official health agencies miss a golden opportunity. They receive birth registration notices, but in most cases these are not received before the baby is two weeks old and the time when the nursing visit would be most appreciated is past. In rural areas arrangements with the local hospital should be made to send a notification of the expected discharge of mother and baby. In only two areas visited were birth lists obtained directly from the hospital.

The organization of child health centres is fairly general, both in urban and rural areas. In the latter, the 'centres' are frequently located in private homes. Unfortunately, some child health conference sessions seem to provide little more than a weighing service. In most, the nurse has a conference with every mother attending. In some of these it would seem to result in little more than the writing of facts on a record, while in others, it is an educational experience for the mother. The quality of the nursing conferences is usually in direct proportion to the in-service education program for the nursing personnel.

Volunteer service could be used more extensively. In one rural area where centres were organized in villages, a local women's group sponsored the centre and was responsible for renting a hall, obtaining the equipment and supplying volunteer service. That 8 of the 19 areas studied are not using volunteers indicates that the nurses are having to spend time on many of the non-nursing duties which could just as well be performed by the non-professional worker. (See page 16 for discussion of the volunteer and full-time lay worker.)

As reported elsewhere, the public health nurse feels that her knowledge of the normal growth and development of the child is inadequate. Granted that more emphasis needs to be placed on this aspect during the public health nursing course, the agency also has a responsibility for continuous staff education. It must also supply the nurse with material to use in conferencing. Excellent literature is available from the Department of National Health and Welfare. Some provincial departments print booklets for use in child health work. One urban agency visited has printed its own material for the use of the nurse in conferencing in child health centres. The information is printed on colored sheets of paper (about 4" x 6"), one subject to a sheet. These are kept in a file box on the desk and the nurse has material at hand on almost any subject on which the mother might request information. A distinct advantage in this method, rather than giving the mother a booklet with information on many topics, is that there can be concentration of teaching and learning of the subject which is most needed. The nurses have, in addition, supplementary information in the form of conference guides which help to keep them up to date. These guides were developed by the nurses in staff education programs and are constantly revised.

Recommendations

Each health agency should review its maternal and child health program with the needs of the community in mind. Where available, private practitioner services should be used to the fullest extent.

1. The health agency should extend its pre-natal nursing program both to group teaching and to pre-natal home visiting. This can be accomplished only if the medical officer of health obtains the co-operation of the local practitioners.

2. Official agencies and visiting nurse associations should share activities in the maternal and child health programs so that the nurses of each agency will have a wider field of interest.

3. The health department should obtain, either through the private practitioner or services of its own physicians, a record of the health status of every infant born in the community.

4. A child health supervision service through public health nursing visits and conferences should be offered by all health departments. The conference should be on an appointment basis and should include pre-school children as well as infants. Public health nurses should be so trained that when a child's development appears satisfactory, leeway could be given them in changing diets and giving advice on normal mental and physical development. Children who appear to be developing normally should continue to be brought to the nursing conferences until such time as a problem arises for which the nurse should not assume responsibility. Such a child should be referred to the private physician, if available, or to the medical officer of the agency.

5. Agencies should give more thought to the preparation and use of educational material for the mother and conferencing guides for nurses in the maternal and child health program.

6. The term "child health centre" is recommended. Facilities should be attractive and easily accessible, preferably on ground-floor level. Facilities for private conferences with mothers should be available to both the physician and the nurse. Signs indicating the location of the centre should be clearly visible.

7. Volunteer help should be used or non-professional assistance employed by the agencies.

Reference

1. Stapley, Maude (Tisdall): An Experiment in Pre-natal Education. The Canadian Nurse, 1948, vol. 44, no. 2.

COMMUNICABLE DISEASE CONTROL

These programs consist chiefly of the implementation of the provincial regulations and of the immunization of children. In six areas the medical officers or the medical staff felt that they should visit some of, if not all, the reported cases of communicable diseases. In two of the larger cities, the district medical officers visited most cases of the common communicable diseases that were reported as having no physician in attendance. In eighteen other health agencies, the physician did not visit cases of infectious disease except when consulted by the private practitioner. In 50 per cent of the health agencies surveyed the public health nurse visited most of the reported cases of communicable disease. In some areas this consisted of a visit to placard and issue instructions regarding care and isolation. In other areas there was a second visit at which time the child was released from quarantine. In 50 per cent of the areas visited, the sanitary inspector or quarantine officer did the placarding and gave instructions regarding isolation and quarantine. In three areas the part-time health officer was responsible for carrying out the provisions of the communicable disease control regulations.

Generally speaking, the medical officers of health in most of the areas visited were not satisfied with the reporting of communicable diseases in their community. They did not feel, regardless of the value of reporting, that the minor communicable diseases were reported accurately. The reporting of the major communicable diseases varied with the practitioner and, all in all, was not satisfactory. It was the opinion that most practitioners considered the communicable disease regulations a nuisance rather than regulations designed to help them in treatment and control.

In some of the larger cities there is a diagnostic service. The parent of a child with a rash decides the child is not sick enough to call a private physician and the health department is called. One of the district physicians is sent to make a diagnosis and either prescribe minor treatment or refer the case to hospital or to a private physician. As an example, in one large city an average of four or five calls a day are made by the district physicians to cases of suspect or diagnosed communicable disease. If the child is ill enough to need the services of a physician, the mother should call a private practitioner. A medical-care service should be supplied by the city for those who cannot afford the services of a private practitioner. If the child is not seriously ill, there is little value in the public health physician's visit in order to diagnose one of the minor communicable diseases. It is difficult to justify this type of service under the guise of public health.

Because of existing provincial regulations in some rural areas, medical officers feel that someone from the health agency staff should visit all cases of placardable communicable disease as they are reported by physicians. In many of these cases the private physician sees the patient, makes a diagnosis, prescribes treatment and reports to the health department, which then sends out either the nurse or the medical officer to placard, diagnose again and discuss isolation and quarantine, all of which should have been done by the practitioner (with the possible exception of the placarding). This tends to make the taxpayer feel that an unnecessary visit has been made to his family by the professional staff of the health agency. The health agency, on the other hand, feels obligated to do this if required to do so by the provincial regulations.

At the present time there is confusion as to responsibility and the use of provincial communicable disease regulations. The communicable disease problem

is not what it was twenty years ago and the public health authorities, realizing this, should be taking active steps to bring their regulations and administrative procedures up to date. By continuing some of the present outdated regulations they are leading the public to believe that control measures are effective, whereas most of the control regulations now in existence are of no effect whatsoever in controlling an epidemic of the communicable diseases of childhood.

Public Health Nursing in Communicable Diseases

The acute communicable disease nursing program is largely concerned with the school age group and therefore is closely linked with the school nursing program. It was impossible to assemble reliable statistics as to visits and time spent on this activity because some agencies would count a visit to a school child with measles as both a 'school visit' and a 'communicable disease visit'. The regulations of the local health department in relation to the control of communicable disease greatly affect the nursing program. For example, if the nurse must visit every case twice regardless of who else may visit it, there is little time for other home visits during certain seasons of the year. The responsibilities permitted the teaching staff are also an important factor affecting the public health nursing time allotted to communicable diseases.

Appendix H, page 78, shows that generally in the urban areas if the nurse is at the school she will exclude the child who may have a communicable disease. It is natural to suppose that if the nurse is in the school building the teacher would want to consult her. In the rural areas, where the visits of the nurse are less frequent, the teacher takes full responsibility for exclusion. Would the control of communicable disease in the school be less effective if the teacher took this responsibility in the urban areas?

In three urban areas, as shown, the nurse visits all cases of communicable disease, and in two of these it is the policy to make a second visit to give a re-admission slip for return to school. This type of visit becomes a routine for obtaining information for an epidemiological record filed in the health department office. The survey visit to one of these urban areas coincided with a measles epidemic. Practically every home visit made by the nurses at this time was for communicable disease, and they were working overtime and on Saturday afternoons. In this same city the quarantine officer also visited all cases, and in the majority of cases the family doctor had been called in before either the nurse or the quarantine officer arrived.

In another city where the nurse is required to visit all cases twice, one nurse wrote in response to a questionnaire, "the part of public health nursing I dislike most is the contagious disease work. I dislike it because it takes too much time away from other work. In my district the majority of cases are under doctor's care, little teaching can be done and as a result only a card is filled in. There is much travelling time used this way." There were many more similar expressions of opinion on the part of the nurses who were required to carry out the policies of the health department.

The duplication of effort is more obvious in rural areas and consequently the nurse usually does the placarding in these areas.

That we are using the scientific knowledge available in the control of communicable diseases is questionable. As stated previously, the nurse must follow regulations, but the nursing technique and procedures need analysis in the light of present knowledge regarding the control of communicable diseases. The majority of the communicable disease home visits are to the school age group. Can we include more of this information in our general health education through the family health service and not wait for a concentration of visits during the time of an epidemic?

Immunization Procedures

Immunization procedures were carried out by a variety of methods in the health agencies visited. In seventeen of the agencies the medical officer himself does the major portion of the immunization. In seven of the areas visited he does none of the immunization. In twelve of the areas the nurses do some or all of the immunization and in the other twelve they do no immunization. In nine areas, part-time or private physicians are employed to help the agency. Because of the varying provincial legislation, public health nurses either give immunization inoculations under the authority of the medical officer of health or they are not allowed to do anything other than to assist the physician. Well-trained nurses can give inoculations at least as well as physicians. The nursing profession in hospitals are giving intramuscular and intravenous treatment. The question is, who is legally responsible in case of accident?

Primarily, the giving of immunizing antigens is the responsibility of the family physician and every effort should be made to encourage parents to go to him. In few of the health agencies visited was this procedure practised. In other words, most health agencies assumed that if the parents wanted to take the child to the private practitioner they would, but no obvious effort was observed in the areas visited to encourage the parent to consult the private physician.

In isolated areas where practitioner services are not readily available it may be desirable for the health agency to provide immunization. In urban areas where a high percentage of the population may be medically indigent, it may be economically more practical for the agency to provide immunization procedures for the child population. However, it should be apparent that the objectives of postgraduate public health training are not to provide the community with a highly paid technician for administering inoculations. Various schemes have been devised by medical officers of health whose departments are under-staffed in an attempt to see that the child population is immunized against diphtheria and smallpox. In some areas the public health nurse makes a survey in the schools and when she finds one that has a low percentage of immunized children she approaches a local community organization and requests them to appoint a local practitioner on a fee-for-service basis. The teacher and the nurse organize the clinic, the physician attends, does the immunizing and collects a nominal sum from the children when they are inoculated. In this way, in several areas, general practitioners have become interested in the public health program and are much more co-operative than previously, and as the community (not the health agency) selected the physician to do the immunizing, there is little objection from the other practising physicians.

In other cases, the full-time medical officer of health goes from place to place doing all the immunizing himself, his nurses having organized the clinics and acting as assistants.

Another scheme is to approach the local medical society and request the members to select certain physicians who will be responsible for operating the clinics on a fee-for-service or hourly payment basis. In other areas, the public health nurse does all the arranging of the clinics, which are usually associated with child health conferences, and does the immunizing herself. In some areas she is assisted by the health unit secretary who is trained in sterilizing and setting up the equipment for the clinics.

Immunization Procedure in Public Health Nursing

In all areas visited where the physician gave immunizations, one nurse, and sometimes two, accompanied him. Her duties were to line up the children, fill the syringes, and do the recording. Sometimes she arrived at the clinic early so that all would be ready. During the survey in one area where the last scarlet fever toxin immunization was being given, there were only five to ten

children in each school to receive the immunization and one doctor and two nurses spent their entire morning on these procedures. It would appear that a study of the use of professional time should lead to a more efficient approach to this important aspect of the public health program.

The following may seem rather irrelevant but it does merit mention. In many areas mothers in child health centres are asked "Are you having 'needles' today?" The meaning of course is, "Is your child having toxoid, or being vaccinated today?" Why not say so? In the first instance the word 'needles' implies a prick and pain. And secondly, it is important that the mother be familiar with the words "immunization", "vaccination", and "toxoid", etc., and know for which diseases protection is given.

Recommendations

1. It is recommended that each province review its communicable disease regulations and, along with other provinces, form a committee to draw up practical regulations for Canada so that professional time will not be wasted in carrying out archaic methods of so-called control.

2. In these regulations more responsibility should be placed on the practising physician and his judgment should be relied upon for release from isolation and quarantine and other aspects of the control program.

3. Provincial legislation should be enacted in all provinces to make it legal for qualified nurses who have received adequate instruction and training to carry out immunization procedures under the authority of a medical officer of health.

4. Each health agency should review its immunization program and devise a method whereby the least amount of professional time is used on these important procedures and whereby the practising physician is brought into the picture as much as possible.

Tuberculosis Control

The amount of time and effort expended on the tuberculosis problem by health agencies depends upon many factors, and the diversity of these factors produces a variety of programs.

In most areas the problem is a major one, but in some, the availability of hospital beds reduces the amount of work required of the health agency, and the activity of voluntary organizations may reduce this requirement further. It was, therefore, difficult to compare constructively the programs of the agencies visited.

From the point of view of this study it may be said that there are too many official agencies who are not participating, or are not allowed to participate fully in the tuberculosis program of their community. Surely it is a sound public health principle that the medical officer of health should have full knowledge of the tuberculosis problem in his community, and that he and his staff are the logical people to handle the preventive aspects of tuberculosis control. They may need assistance from tuberculosis specialists in the diagnosis and treatment of the disease, but the major portion of the case finding, follow-up, and home supervision should be part of the everyday work of the official public health agency. The fact that a volunteer agency or a specialized staff is doing a good job does not justify their retaining this service when the official health agency can provide the service as part of its generalized program. There is work for volunteer associations in the field of public education, seal sales, and other aspects of the tuberculosis problem more suited to a non-official agency. Because of the multiplicity of agencies interested in the tuberculosis program there is frequently a lack of co-ordination of effort.

In many areas the hospitals do not use the health agency as a source of information regarding home conditions and contacts, and the health agency does not exchange data with the hospital regarding the follow-up of discharged patients. In many areas there is little exchange of information between the volunteer organization and the official agency. This lack of co-ordination may result in duplication of effort, incomplete service to the community and a decrease in job satisfaction for the professional public health personnel.

Public Health Nursing in Tuberculosis Control

The tuberculosis nursing program is closely related to the incidence of the disease and the availability of beds for hospitalization. In many areas the follow-up nursing service is specialized.

Of nine urban areas studied:

Five had the nurses of the local health department responsible for the public health nursing aspects of the tuberculosis program.

Two of the local health departments had special nurses for the tuberculosis home follow-up.

Two had the nursing program carried on by nurses of a voluntary agency.

Of ten rural areas studied:

Six had the public health nursing aspects of the tuberculosis program as part of the generalized service of the local health department.

Two had the nurses of the local health department visit only cases referred by the sanatoria or the local voluntary tuberculosis association. Most of the cases referred are those that had become delinquent in their acceptance of treatment.

One had the program carried out through the medical clinic; visits by the nurses are only incidental.

One had a special nurse engaged for the tuberculosis control program.

The above information indicates that in many areas a public health nursing program based on a family health service is far from being the practice.

The tuberculosis nursing program is one for which it is very difficult to measure the effectiveness of a public health nursing service. If there are x-ray surveys for case finding, available beds, and adequate legislation, the work of the nurse in control is minimized—her function becomes that of a health adviser in the family health service, teaching the prevention of the disease. Many public health nursing supervisors recognize that there is not sufficient emphasis on this aspect. As one expressed it, "the nurses are just acting as policemen, chasing up the contacts for examination". Here again is where a staff education program is needed to help the nurses to incorporate education for the prevention of tuberculosis into the family visit.

In most areas there is not a sufficient exchange of information between the local health departments and the sanatoria. The progress of the patient in hospital is very dependent on home conditions and yet very few health departments have requests for information. Again, when the patient is ready for discharge, it is important to know under what conditions he is living, but few requests for such information are made to the health department. All too frequently, notice of discharge is received some time after the patient is home. A few urban and rural areas visited are outstanding exceptions to this. In these areas there is an exchange of information and patients are not discharged before the health agency investigates and sends in a report of home conditions.

Because, in tuberculosis, the health and welfare aspects are so closely linked, the health agency is greatly handicapped in providing the most efficient service unless there are:

- (a) adequate facilities in the community for welfare needs,
- (b) Consultant social case work services available for those patients with problems which require more intensive service than the health personnel can provide.

In many areas visited the community welfare facilities were inadequate and the nurse was spending a large proportion of her time on the strictly welfare aspects of the problem. In only two areas visited was consultant social case work service available for the tuberculosis patient.

Comment

Tuberculosis work is one of the interesting and satisfying jobs of public health. Due to the natural tendency for most professional people to become more interested in a special aspect of their work, specialization results. Public health is faced with two alternatives, either to develop a specialist for every aspect of public health and send a number of different workers to the home, all in the name of public health, or develop a generalized program with as little specialization as possible in so far as contact with the family is concerned, and have consultant specialists available for staff training and consultation.

As with some other problems of public health in the past, it was necessary for voluntary organizations to demonstrate to the public the need for government participation in the provision of tuberculosis care and the institution of control measures. Much of the credit for the present-day progress is due to the voluntary agencies but now that they have adequately demonstrated the need for such services, the official agencies should be made responsible.

Recommendations

In order to conserve professional effort, increase the general interest in public health work, and provide an efficient service, it is recommended that each provincial health department convene a committee of those organizations interested in tuberculosis control and define clearly the role of each agency or organization. Under a central co-ordinating division of the health department, the various aspects of the control program should be allocated to the agencies best suited to the particular problem. Where there is an official health agency, the administration of the program and the public health nursing supervision should be the responsibility of the agency as part of its generalized public health service.

Venereal Disease Control

In all the provinces except one, there is a central division of venereal disease control. In two provinces the central division does all the contact tracing and supervises most of the treatment that goes on in the province other than private treatment. In six other provinces the central division does the major portion of the contact tracing but where there are organized health units and city health departments they assist in the contact tracing and the case follow-up. In the province that does not have a central division, the units and cities do their own contact tracing and case follow-up. Under the Venereal Disease Control Acts in the various provinces the physician is required to report directly to the provincial department of health all cases of venereal disease coming to his notice. This procedure is followed in all provinces except one, in which the physician reports directly to the medical officer of health in areas where there is an organized health department and the medical officer of health then institutes contact tracing and follow-up with his own staff.

In the past it has been found difficult to obtain adequate reporting of cases from practising physicians, particularly in areas where there were no full-time health officers. Practising physicians are loathe to report cases of venereal disease to a part-time medical officer of health. In order to overcome this during the war period when not only were there few part-time medical officers of health but the ranks of the full-time officers were seriously depleted, the provinces decided that a more efficient job could be done if the central division of venereal disease control took upon itself the responsibility for collecting information regarding cases and issuing instructions regarding contact tracing. This proved very successful in so far as the war effort was concerned, but now that there are numerous full-time health departments in Canada, it would seem advisable for those provinces that still maintain central authority to consider allotting to the full-time health departments the collection of data relating to cases and contacts; in other words, adding venereal disease control to their generalized program. This leads to better job satisfaction both on the part of the district medical officer of health and of the public health nurses, for as previously stated under Tuberculosis Control, the organized health departments should be responsible for public health problems within their own areas.

Except in areas where there is a large transient or medically indigent group, venereal disease treatment should be the work of the private physician. Where it is necessary to establish clinics, this service should be part of the local health department program and not an isolated provincial department, having no relation to the local health authority.

Public Health Nursing in Venereal Disease Control

Venereal disease nursing follow-up is frequently not included in the generalized program but it may be said that there is an increasing tendency to have this service, so far as practicable, carried by the district public health nurse.

Of nine urban areas studied:

Two had nurses of the local health department responsible for case holding.

Three had the venereal disease program as a specialized service of the provincial department.

One also had a specialized service by the provincial department, but the follow-up was done by a social worker.

Three had a specialized service in the local health department.

Of ten rural areas studied:

Six had nurses of the local health department responsible for both case holding and contact tracing.

Two had nurses visit only cases referred by the provincial department.

One had a specialized service by the provincial department.

One had all follow-up done by the medical officer of health.

In the two urban areas where case holding is a part of the generalized nursing program, the contact tracing is done by specialized workers (usually nurses) of the venereal disease control division. The consultant services of a medical social worker are available to the nurses in one area.

There was considerable difference of opinion as to whether the public health nurse should do the contact tracing and the case holding in her own area or whether she should do just the case holding and leave the contact tracing to a specialized worker, or whether the whole service should be a specialized service within the local department, or a specialized service carried on by provincial employees with little or no relation to the local agency.

With the exception of certain urban areas where the venereal disease problem is great, there does not seem to be any reason why the public health nurse cannot efficiently carry out contact tracing as well as case holding. In the aforesaid urban areas there are certain problems such as volume of work, the type of individual in the contact tracing, etc., which would indicate that a specialized service involving specially trained workers would probably be a more efficient use of trained personnel. However, such specialists should be part of the local health department and the medical officer of health should have full knowledge of the venereal disease problem as it exists in his area.

Recommendations

1. Each province should review its venereal disease regulations and revise them where necessary so that (a) each full-time health department would have full knowledge through direct reporting of the venereal disease cases occurring in their area and (b) where feasible, the local health staff should be made responsible for case follow-up, holding and contact tracing.

2. In each province a central venereal disease control division should be established either separately or as part of the general communicable disease control work. The function of such a division should be the collection and recording of all case and contact records reported to the department through the full-time health units or from individual physicians in unorganized areas. The central division should be responsible for supplying free biological products and drugs, where necessary, to private physicians for treatment and such divisions should be responsible for subsidizing the operation of clinics where necessary in urban areas, but such clinics should be staffed by members of the local health department or local hospital under the supervision and/or direction of the local health department.

MENTAL HEALTH

Mental health has been included as a specific item of the public health program relatively recently. The health agencies visited had a variety of services called mental hygiene. Many of these had not progressed past a diagnostic and treatment service, while in other areas an attempt was being made to meet the need for preventive services. Seven agencies had no specific program or consultant services available.

Eight urban areas studied had some facilities for a mental health program—

- (a) In six the facilities were under the local health department.
- (b) In one the clinic was operated in conjunction with the medical school.
- (c) In one it was co-operative between the health department and the board of education.
- (d) In five the district public health nurse prepared the history for the case, made the referral to the clinic, received a report of the examination with recommendations and did the follow-up home visiting.
- (e) In two of these five areas there was further participation by the public health nurse in that she was present at the conference along with other workers concerned (social workers, teachers) when the case was discussed and recommendations made.
- (f) In one area the district public health nurse had little participation in the mental hygiene program since there were nurses on the staff of the mental hygiene division and it is, therefore, a specialized nursing service.
- (g) In two areas the nurses referred the case only. No report was made to the nurse. In one of these a psychiatric social worker visited the home, prepared the history and did the follow-up home visiting.

Six of ten rural areas studied had some facilities for a mental health program.

- (a) In five the nurse prepared the history, made the referral, received back a report of the examination with recommendations and did the follow-up home visiting. In one of these the nurse was present at the conference, along with other workers concerned.
- (b) In one area the nurse referred the case only.

In the majority of agencies offering a mental health service, the medical officer of health plays an administrative part only. The program is usually directed by a psychiatrist on a part-time basis. Frequently he is a provincial employee and serves several health agencies. While there is a real need in most Canadian communities for specialist services in psychiatry, there is a greater need for a program designed to prevent mental problems before they become serious enough to require specialist care.

There is a tendency to assume that unless an agency has a mental hygiene clinic it has no mental health program. Surely the opportunities are unlimited in general public health work to help establish a healthy mental attitude in the people with whom we have contact. It has been stated that the mother-child relationship might form the best single strategic point of attack on which public health effort should be focused in order to have a maximum effect. By relieving anxiety and building up the mother's mental security, the public health worker in contact with the mother and child at the child health conference has an opportunity to do more for the mental health of the community than in any other way.

It is not usual for the district public health nurse to participate actively in the post-discharge supervision of a case from a mental hospital. In one province, however, the mental health program has been organized to include this as one of the public health nursing activities. The nurses are all given a month of intensive orientation to the work at one of the mental hospitals. When a case is discharged, the district medical officer of health receives a report and the nurse is responsible for follow-up in the home just as she would be responsible for the home supervision of a case of tuberculosis. This is a further step toward a more complete generalization of the public health nursing program and adds greatly to the interest of the nurse in her work.

Mental Health Content in the Child Health Program

The mental health program is not limited to the referral of special cases to a mental health or child guidance clinic. As a matter of fact, probably the most effective part of the program is the teaching done by the public health nurses, especially in the maternal and child health field. Seven per cent of the questions asked by the mothers in relation to infants could be classified as relating to mental or emotional problems (Table III, page 35). But the public health nurse in answering many questions classified under the other headings was incorporating mental health teaching; for example, when discussing such practical matters as the addition of new foods to the diet, the kind of clothes the pre-school child should wear, the most suitable toys, etc.

Comment

No agency should feel that it cannot give a mental health service if it does not have a mental hygiene clinic. The everyday routine of the health officer and the nurses affords ample opportunity to do more for the mental health of the community than the diagnosis and rehabilitation of the occasional neurotic child. It is thought that the reason some health agencies are not taking advantage of this opportunity is because the physicians and nurses have not received sufficient training in their undergraduate or post-graduate preparation. This, of course, might be corrected by a revision of the training curricula. In addition, it appeared to the survey team that the most efficient method of utilizing the few psychiatrists who were available to health agencies was for the in-service training of public health nurses, teachers and physicians, so that they might be better prepared to take advantage of the many opportunities for the promotion of mental health in the total health program.

Recommendations

1. The public health nurse should be used to the greatest possible extent as the field worker in the specific mental health program.
2. Specific mental health programs under psychiatric direction should be used primarily as staff training projects in order to increase a positive mental health approach to these problems by public health physicians and nurses.

ENVIRONMENTAL SANITATION

With the exception of a few of the larger cities, the local or municipal health departments of Canada do not have public health engineers on their staff. All of the provinces have a division of environmental sanitation or public health engineering and public health engineers are available for consultation to the health units and smaller cities.

The ratio of sanitary inspectors per thousand population varies greatly in the health departments and units in the areas visited. In some of the larger cities where there is an active department of environmental sanitation, the ratio is one sanitary inspector per seven thousand population. The other extreme is in certain health units where there is not a sanitary inspector. The overall average in organized health agencies is approximately one sanitary inspector to every 10,000 people in urban areas and one to every 15,000 in rural areas.

One of the major problems encountered by urban health departments is the volume of complaints regarding nuisances. Most of this work is carried out by the sanitary inspection staff, but many of the problems finally reach the desk of the medical officer of health, and in the medium-sized cities they take a large proportion of his working time. A job analysis or time study of this problem was not encountered in any of the health departments visited but the general impression was that the time required to deal with nuisance complaints was far in excess of the value derived from the service. Most medical officers of health were of the opinion that many of the nuisance complaints which came to the health department for action were not the responsibility of the health department at all but a disciplinary problem for the law-enforcement body of the community. Several factors have brought about this situation. In the past, health departments, because of the vagueness of municipal and provincial health laws regarding the definition of the term "nuisance", were forced to accept responsibility for community problems which in many cases were not actually health problems. This acceptance of law-enforcement responsibility has led to the public belief in urban areas that the health department is the place to go if there is a nuisance problem which even remotely, in the minds of the public, is connected with health or welfare. The health department, on the other hand, when phone calls of this nature are received, has to investigate the complaint to ascertain if a health problem is involved, and this is time-consuming. There is a considerable variation in the attitude of sanitary inspectors and medical officers of health as to their part in the correction of community nuisances. Some health departments feel that they should prosecute and the health staff, including the medical officer of health or his sanitary inspection staff, spend considerable time laying charges, appearing in court and giving evidence. Other departments avoid disciplinary action as much as possible. While it is obvious that by-laws and health regulations are needed for the protection of the public, it would seem that far more effort could be made in educating the public than is being done at the present and less inspection work of a disciplinary nature carried out. Of 21 health departments reporting on one aspect of the educational campaign, only two give regular food handlers' courses. Seven of the departments have conducted at least one course, but not regularly, and twelve departments have never arranged for a course for food handlers in their community.

In some large urban areas many complaints are received by telephone. It is suggested that if the complaining person were requested either to visit the health department and thoroughly explain the complaint, or put it in writing and submit it to the medical officer of health, numerous minor complaints which have nothing to do with health would not reach the health department.

To change the attitude and the habits of the public regarding what they think a health department should do in nuisance control will require several years. However, if health departments are to retain their status as health advisers to the community, it is essential that matters which have nothing to do with health should be deleted from the program, particularly those which require disciplinary action.

If it is an accepted principle that the educational approach is the best method of handling the environmental sanitation problem of a community, then public health workers must realize that all the health education required in a community in excess of the department of education programs in schools, cannot be carried out by the physicians and nurses. Consequently the sanitary inspection staff will have to accept more responsibility for teaching the public as well as watching the sanitation practices of the various places where insanitary conditions may constitute a hazard to the public health. The present standard of educational qualification required for sanitary inspectors' positions does not provide, in most cases, a person with the requisite training to accept this teaching responsibility. While the inspectional and individual teaching work of the sanitary inspector will be a requirement of health departments for many years to come, it is just as obvious that health departments should be planning for the services of a university graduate with training in educational methods and in environmental sanitation, who in the role of community sanitarian will aid the medical officer of health and his staff to a greater degree in the teaching of health in the community.

HOUSING

One of the most controversial subjects was the position of the health department in reference to current housing problems. Most of the urban centres visited had some type of planning board but the extent of the work of these boards varied so much that it was difficult to assess their value in the short time of the study.

In only three of ten urban centres were the medical officers or members of the staff taking an active part on the planning board. Others were used in a consultant capacity but had no official position on the board. In most of the areas studied the health department confined its activities in housing to the inspection and condemning of substandard housing. In certain areas local by-laws or provincial regulations gave the medical officer of health power to force landlords to rectify insanitary conditions in dwellings by the stoppage of rental or the applying of rents to the costs of the necessary repairs.

It was the unanimous opinion of the medical officers that adequate housing would solve a great many of the public health problems of their community. For this reason it is hard to understand why health departments do not take more interest in the long-range planning for the solution of their community housing problems. It may be that the health department staff is discouraged by the petty political interference which is brought to bear in most communities when the subject of housing is broached.

Recommendation

It is recommended that health agencies take an intensive part in the planning of housing for their communities. This work should include studies of population trends, housing codes, morbidity and mortality statistics in relation to housing quality, and any other activity which will help the community to appreciate the value of good housing as a public health measure.

ACTIVITY ANALYSIS OF PUBLIC HEALTH NURSING

When planning the study of public health nursing practices, the Study Committee stated that they wanted to know, first, what the public health nurse is doing. From an analysis of this information, together with other related facts, what she should be doing might be determined. Finally, it would be necessary to outline what she should know; that is, the curriculum content for preparation in public health nursing.

Two methods were used to find out what the public health nurse is doing:

- (a) Observation and interview.
- (b) Obtaining a list of activities from a representative number of nurses in each agency studied.

The findings are published in Appendix A, "Activity Analysis of Public Health Nursing". A review of the items listed will reveal that many of the activities are not those that have been commonly considered as nursing functions. For example, "selling vitamin pills". If it is the policy of the health agency that vitamin pills be made available to school children, should not some method of distribution other than using professional time, be found? Or should the policy be changed? Is the "administering of intelligence tests" a wise use of nursing time? Or is it the function of another professional worker? To what extent is the "transportation of patients to hospital or clinic" a public health nursing responsibility? Could the "cleaning of equipment and supplies" be done by a non-professional assistant?

It is very difficult to define nursing, and even more difficult to define public health nursing.

The facts presented in this study show that the shortage of public health nurses is both qualitative and quantitative. They indicate also that there are nursing responsibilities which are not being met in many communities, activities which nurses are doing which might be done by another worker, and some which might be eliminated. Due to the variation in problems confronting local health departments and the resulting variety of nursing activities, it is impossible in this study to make more than general recommendations. From this point an assessment of "the work that nurses now perform" must be done in each local situation through a job analysis.

This will determine:

- (a) those activities which are essential.
- (b) which of the essential activities are functions of public health nurses.
- (c) which of the essential activities should be performed by another professional worker.
a non-professional assistant.
- (d) activities which could be eliminated.

As it was realized that the time allotted to the study would be sufficient only to collect and analyze the facts and make general recommendations, the question of the compilation of a list of functions (what the public health nurse should do) was discussed with a committee of the Canadian Nurses Association. Although it was decided to wait until the findings of the present study were available, the committee members were not sure that it would be advisable or necessary to formulate a list of functions.

Three factors contributed to this opinion:

- (a) The variation in public health problems with the local situation, and a resulting variety of public health nursing activities, would necessitate a very general statement of nursing functions.
- (b) The fact that for the United States the National Organization of Public Health Nursing have recently published a list of "Public Health Nursing Responsibilities in a Community Health Program (1) "which the committee (Canadian Nurses Association) considered were general enough to be applicable to Canada."
- (c) The difficulties in defining nursing (2), (as indicated previously).

A determination of what the public health nurse should know involves a further study. The need for this has been indicated in the material presented under "The Preparation of the Public Health Nurse".

It is clearly not a function of the Canadian Public Health Association to undertake a curriculum study for public health nursing. Such a study has been initiated on a voluntary basis by the Council of University Schools and Departments of Nursing which have collected sufficient data to indicate the necessity for the continuation of the project under full-time direction.

Additional information concerning nursing in related agencies, industry and in the hospital is included as Appendices B, C and D.

References

1. Public Health Nursing Responsibilities in a Community Health Program, Public Health Nursing, 1949, Vol. 41, No. 2.
2. The Committee on the Function of Nursing. A Program for the Nursing Profession, The Macmillan Co., N.Y. 1948, pp. 29, 30.

THE PREPARATION OF THE PUBLIC HEALTH NURSE

There have been many who have questioned whether the public health nurse requires the same basic preparation as the hospital nurse. Their queries have been based chiefly on: the length of time taken—one year following a basic three-year course; and the need of the public health nurse to use many of the skills required by the nurse in hospital.

The majority of our schools of nursing, on which hospitals are dependent for services, require three years to prepare a nurse, and in the majority the health aspects are not integrated. The Canadian Nurses Association is conducting an experimental school which is financially independent of the hospital with which it is associated. There is affiliation in the specialties of tuberculosis, psychiatry, communicable disease and public health. This experience is not given with the objective of preparing a public health nurse, but rather of preparing a better clinical nurse. This basic nursing course is approximately 25 months. Further, on this foundation, if the nurse desires to enter the public health nursing field, she can add a year of postgraduate work in public health nursing, and in three years she should be as well prepared for her specialty, or even better, as those spending four years at present (*i.e.* three years' basic training and one year of specialized study).

For the nurse wishing to obtain a degree, there are two universities offering a course in nursing which will prepare her for practice both in general nursing and in public health nursing. The public health aspects are integrated throughout the period and are not given through a final year of specialized work, as in other university schools and departments of nursing. This preparation requires five years. A third university has recently announced a plan to establish a basic course in nursing of approximately four years. This will be a degree course and will prepare the student for general nursing and public health nursing.

There is a great variety in public health nursing practice across Canada. All visiting nurse associations give a bedside nursing service which requires the skills of general nursing and, in addition, the ability to teach health, which is the foremost function of the public health nurse. There is an increasing move in official public health agencies to include an emergency and demonstration bedside care program. In the northern parts of the prairie provinces the district nurses are doing a considerable amount of midwifery, and in an emergency, even minor surgery. They are responsible also for the health education program. For a long time to come, we will have such areas far away from a doctor and a hospital.

As well as this variety in practice for which the public health nurse must be prepared, there is in nursing, as in other professions to-day, a great movement of personnel. Almost without exception, directors of public health nursing have remarked on the great turn-over of staff. Of 688 nurses employed in official health agencies, both urban and rural, and for whom the information is available, 21 per cent had been with the agency less than one year, another 50 per cent had been with the agency less than five years, and the remaining 29 per cent had been five years or over with the same agency. Information was made available for another large group of nurses having a staff turn-over in 1948 of 29 per cent.

It is, therefore, necessary that our hospital and university schools of nursing think in terms of preparing nurses for service in any part of Canada, and not for one selected area or type of practice.

In 1934, Miss Ethel Johns and Miss Blanche Pfefferkorn prepared, under the auspices of the Committee on the Grading of Nursing Schools, an activity

analysis of nursing (1). They asked—"What is good nursing?" and reached the following conclusions—

- "1. All professional nurses, irrespective of the special field in which they have elected to practise, should be able to give expert bedside care. They should also have such knowledge of the household arts as will enable them to deal effectively with the domestic emergencies arising out of illness.
- "2. All professional nurses, irrespective of the special field in which they have chosen to practise, should be able to observe and to interpret the physical manifestations of the patient's condition and also the social and environmental factors which may hasten or delay his recovery.
- "3. All professional nurses should possess the special knowledge and skill required in dealing effectively with situations peculiar to certain common types of illness.
- "4. All professional nurses should be able to apply, in a nursing situation, those principles of mental hygiene which make for a better understanding of the psychological factor in illness.
- "5. All professional nurses should be capable of taking part in the promotion of health and the prevention of disease.
- "6. All professional nurses should possess the essential knowledge and the ability to teach measures to conserve health and to restore health.
- "7. All professional nurses should be able to co-operate effectively with the family, hospital personnel and health and social agencies in the interests of patient and community.
- "8. Every nurse should be able, by means of the practice of her profession, to attain a measure of economic security and to provide for sickness and old age. It should be possible for her to conserve her physical resources, to seek mental stimulus by further study and experience, and to follow that way of life in which she finds those spiritual and cultural values which enrich and liberate human personality."

These conclusions still apply for all nursing, including public health nursing.

There has yet to be suggested an acceptable method of giving basic preparation for public health nursing other than through a general course. It is granted that the basic course can be improved for the benefit of all nursing. The following indicates a lack of experience in three fields in which it is considered that all students should have experience before graduation. Of 164* nurses who graduated in 1949 with a certificate or diploma in public health nursing, 69 per cent lacked experience in tuberculosis, 82 per cent in psychiatry and 61 per cent in public health (either experience or observation with a community health agency).

Table IV, page 56, shows the number of schools of nursing in Canada offering experience in these three fields. It indicates that 34 per cent of students are in schools where experience is offered in tuberculosis; this, however, should not be interpreted as the number who actually receive this experience. In many of the 45 schools shown, the affiliation is either an elective for students or is on a selective basis. In only one province must all students have experience in tuberculosis nursing, and there it is a requirement stated in the Nursing Act. Similarly, many of the schools offer the experience in both psychiatry and public health on an elective or selective basis. Even in the provinces where all schools offer psychiatric experience, it is given to only a small percentage of students.

*Statistics available from eight of the nine universities graduating public health nurses in 1949.

In relation to undergraduate public health experience, observations made during the course of the present survey show that the length of the period of so-called "public health experience" with the official agency varies from one day to one month. The majority seemed to be one to two days; where there was affiliation with the visiting nurse agency, it was usually for a longer period. There was a great variety in the kind and amount of planning done for the student. In one large centre all the students received an introductory lecture from the educational director of an agency where they had three days' observation. At the end of their experience each small group had a conference with the educational director and a short written assignment was discussed. In the majority of agencies there seemed to be very little planning, and one must report with regret that some public health nurses consider the student a nuisance. In all too many cases the student is just given an odd job to do to keep her occupied, such as weighing patients in a pre-natal clinic, taking temperatures, etc. It was noted that the agencies who gave some thought to the planning of an educational experience for the student, even though it was for a short observation period, were creating interest in public health as a future career, and ultimately would make more recruits. No agency should accept responsibility for a student affiliation without a planned program (which should be in writing) and a staff capable of carrying it out.

Change and improvement in the preparation for public health nursing cannot end in the basic course. The following are some facts from a questionnaire prepared by the Council of University Schools and Departments of Nursing and sent to all universities offering a course in public health nursing. Eight of the nine universities offering preparation replied.

1. From these eight universities 164 nurses graduated in the spring of 1949, with a certificate or diploma in public health nursing. In addition, 67 graduated with degrees in nursing. Of these 67, 35 took their public health nursing preparation along with the certificate or diploma group.
2. These eight universities state they could accommodate 127 more public health nursing students in the certificate or diploma courses than they have at present. The factors limiting still further accommodation are stated in almost all cases as lack of facilities for adequate experience.
3. Of the eight universities, 6 offer a degree. The degree may be B.N., B.N.Sc., B.Sc.N., B.Sc., B.A.Sc.
All offer a one-year course in public health nursing; four refer to it as a "certificate" course and four a "diploma" course.
4. Field Work—Three months is the general length of time given to field work, although this is two months in two universities. In all cases the student has field work experience in a visiting nurse agency. The official agency experience nearly always includes urban but not always rural. (Approximately 68 per cent of official agency public health nurses in Canada are engaged in rural work.)
5. The total hours of lectures (exclusive of field trips, observation periods, etc.) ranged from 242 to 612.
6. The number of subjects listed ranged from nine to seventeen.
7. The following table shows variations in time allotted to some specific subjects or lecture courses:

TABLE IV
SCHOOLS OF NURSING IN CANADA

Province	Total Number Schools	Total Number of Students	No. of Schools Employing P.H.N.	Number of Schools Giving Nursing Experience in:*					
				Tuberculosis		Psychiatry		Public Health	
				No.	Per cent	No.	Per cent	Total Students	Per cent
B.C.	6	1102	0	6	100.0	6	100.0	1102	100.0
Alta.	11	1059	4	3	14.0	1	2.8	557	52.1
Sask.	10	1049	4	10	100.0	1	19.1	632	60.2
Man.	11	861	1	4	24.3	4	44.1	599	69.6
Ont.	64	4407	18	10	1182	43	75.3	2843	64.5
Que. Eng.	7	793	1	1	32	1	39.0	793	100.0
Fr.	30	1652	0	4	205	5	21.9	451	27.3
N.B.	14	668	0	1	7.3	0	—	99	14.8
N.S.	15	862	0	7	41.4	2	21.8	446	51.7
P.E.I.	3	118	0	0	—	0	—	—	—
Total	170	12,581	28	45	4335	62	46.7	7522	59.8

*Information from publication by Canadian Nurses Association, "How to Choose a School of Nursing", 1947, and interviews during survey.

There is a great variation in the professional background of the nurses who register in public health nursing courses. They may come from any one of the 168 hospital schools of nursing in Canada and they may or may not have had experience as a graduate nurse following the basic preparation. One university, in the 1948-49 term, used the pre-tests of the Merit System Service of the American Public Health Association. These tests have been used with some success in many of the programs of study in public health nursing in the United States. They have been valuable as a way of discovering a student's general strengths and weaknesses, as an indication that the content of courses should be changed or their sequence altered, and, at the completion of the course, as a method of determining whether or not the student has acquired the necessary knowledge, and as a means of helping the student to decide in what she needs further study or experience.

Public health nurses, with experience following their course, have had some comments to make in relation to their preparation. Many indicated the need for more background in mental health. They suggested that this should be integrated in all fields—in pre-natal, post-natal, infant, pre-school, school and adult nursing supervision. Along with mental health many included the need for an understanding of the principles of psychology.

Both supervisors and staff nurses remarked on the general lack of information about the normal development of the child. The greatest need is for more of the knowledge which would help them to conduct good conferences in child health centres. It is perhaps in the consideration of the normal development of the child that there is the greatest need for the integration of mental health.

More and more public health nurses are recognizing that the teaching of normal nutrition is one of the important elements of the health education program. They realize that they are poorly prepared in this field. They want a knowledge of practical nutrition and budgeting and, along with that, a knowledge of the various educational techniques which are needed to teach effectively.

Many nurses, and especially those in rural areas, expressed the need for more preparation in speaking to community groups. Most nurses who have had in their course the giving of classroom lessons felt that this did not carry over as a preparation for individual or group teaching.

Many expressed a need for more emphasis on the techniques of interviewing.

Summary

1. There has yet to be found an acceptable method of preparing a nurse for public health, apart from the study of clinical nursing, but there can be an improvement in the present courses.
2. The universities offering preparation in public health nursing could accommodate more students.
3. No minimum recommendations for public health nursing courses in Canada have been made.
4. There is a wide variation in the content of present courses.

Recommendation

As it is not the function of the Canadian Public Health Association to undertake a study of the education of nurses, this matter is referred to the Education Committee of the Canadian Nurses Association and the Council of University Schools and departments of nursing with the recommendation that a study be made of the methods of preparing nurses so that they may be more fully qualified to contribute to the community's health services.

It would be helpful if this recommendation be considered in the light of the following:

- I. (a) The need for an increased emphasis upon the health aspects in the undergraduate curriculum of the hospital school of nursing.
- (b) The need for the extension and improvement of the facilities for the preparation of public health nurses:
 1. In the university schools and departments of nursing now providing an experience in which the curative and preventive aspects are integrated.
 2. By other university schools and departments of nursing, not now giving this type of preparation, changing their program to provide an experience in which the curative and preventive aspects are integrated.
- II. For many years to come, the greatest number of public health nurses will be prepared through the basic course of a hospital, with an added year of preparation in public health nursing at a university. There is, therefore, a need for study of the present one-year certificate and diploma courses, for the purpose of recommending desirable standards.
- III. It is suggested that university schools and departments of nursing might experiment with pre-tests for public health nursing courses, and if these prove of value standard tests be developed for use in Canadian universities offering preparation in public health nursing.
- IV. Since at present most university schools and departments of nursing do not have as many public health nursing students as they could accommodate, there is need for greater emphasis on recruitment for public health nursing, by:
 - (a) Encouraging schools of nursing to send students for observation or experience.
 - (b) Providing a planned program for this observation or experience.
- V. Since one of the factors limiting a greater enrollment of public health nursing students is inadequate facilities for field experience, public health agencies should make every effort to extend and improve facilities for public health nursing students.

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1. Johns, Ethel, and Pfefferkorn, Blanche: An Activity Analysis of Nursing, prepared under the auspices of the Committee on the Grading of Nursing Schools, New York City, 1934, pp. 40-41.

APPENDIX A

ACTIVITY ANALYSIS OF PUBLIC HEALTH NURSING

One hundred and fifty-eight staff public health nurses, of whom 29 were members of visiting nurse agencies, 91 were members of official agencies in urban areas, and 38 were members of official agencies in rural areas, made a list of their activities. A few items were added that had not been included by the nurses but were observed by the surveyor. In some cases the wording has been changed to make the construction parallel, but the ideas have not been altered.

1. Activities in relation to bedside nursing care:

- (a) Care of chronic patients in the home. (This includes cardiac, paraplegic, diabetic, cancer, arthritic, senile, etc.)
 General nursing care—bed or tub baths.
 Teaching the patient the importance of health and how to care for self.
 Teaching the patient how to do above procedures for himself.
 Teaching some capable person in the family how to care for the chronic patient; mental as well as physical aspects.
 Teaching principles of nutrition required.
 Being aware of, and using, the principles of psychology and mental hygiene in relation to the chronically ill.
 Performing procedures such as the following:
 Injections—insulin, liver, vitamin B, penicillin, streptomycin.
 Hair shampoo; enemas; urinalysis; gastrectomy feeding; surgical dressing.
- (b) Care of acutely ill in the home.
 General nursing care.
 Care of mouth, bed sores, etc.
 Performing procedures such as:
 Enemas: catheterization; bladder irrigations; vaginal irrigations; colostomy irrigations; colonic irrigations; ear and eye irrigations; surgical dressing; fomentations; giving of medications; removing sutures.
 Teaching a capable person in the family as much as possible about the care of the patient.
 Teaching patient the importance of health and how to care for self.
 Teaching principles of nutrition.
 Setting up isolation precautions for communicable disease and teaching members of family.
 Teaching sterilization technique and reasons for use.
 Assisting doctors with operations in the home; e.g., circumcision, opening of abscesses.

2. Activities in relation to pre-natal and post-natal nursing supervision:

- (a) Through home visiting, health teaching in relation to:
 1. Pre-natal care and hygiene of pregnancy.
 2. Prevention of complications and discomforts of pregnancy.
 3. Clothes for the mother and baby.
 4. Breast feeding.
 5. Nutritional needs.
 6. Family relationships to the expected baby.
 7. Preparation for the baby's bath, etc.
 8. Preparation for home delivery.

9. Signs of labour and preparation for hospital.
- (b) At clinic:
 1. Health teaching as above.
 2. Assisting the doctor.
 3. Taking of blood pressures.
- (c) Organization of and teaching pre-natal classes.
- (d) Home confinement:
 1. Preparation for delivery.
 2. Calling the doctor at the right time.
 3. Assisting the doctor at delivery or delivering baby if doctor not present.
 4. Administration of ether under doctor's instructions.
 5. Care of the newborn.
 6. Care of the mother following delivery.
- (e) Post-natal:
 1. Care of the baby and teaching mother how to care for baby.
 2. General nursing care of the mother and health teaching about rest, exercise, diet, post-natal examination, breast feeding, etc.
 3. Teaching preparation of formula.

3. Activities in relation to the infant and pre-school age group:

- (a) Home visit:

Discussing with mother and father all aspects of the physical and mental development of the infant and pre-school child.

Observations of home environment and how child reacts.

Judging amount of knowledge parents are capable of absorbing and using.
- (b) Child health conferences.

Arranging for volunteers.

Supervision of volunteers.

Assisting the doctor.

Conferencing with mother:

 1. Regarding diet and formula.
 2. Regarding immunization.
 3. Regarding general physical, mental and emotional development.

Administration:

 1. Set up clinic.
 2. Assist doctors.
 3. Make appointments.
 4. Keep records.
 5. Set up immunization tray.
 6. Keep syringe, needles sterilized.
 7. See that clinic quarters are attractive.
 8. Tidy clinic and put away equipment.

4. Activities in relation to the school nursing program:

- (a) In school.

Inspection of children.

 1. Rapid inspection in class room.
 2. Individual physical inspection including—vision testing; hearing testing; weighing and measuring; observation of condition of teeth, throat; gland; head; posture; feet; general skin tone; general appearance and response.
 3. Seeing children sent by teacher for examination.

- (a) Health counselling of individual child.

Conferencing with principal and teacher regarding individual children.

Acting as a consultant in health education to teacher.

Interpreting the home conditions to teacher.

Interpreting doctor's findings to principal and teacher.

Health talks.

Control of communicable disease through:

 1. Instruction to the teachers regarding early signs of communicable disease.
 2. Inspection of children with signs of communicable disease.
 3. Exclusion from school.
 4. Re-admission of those previously absent.
 5. Arranging for immunization.

Preparation for physical examination.

 1. Screening with the teacher.
 2. Collecting all available information on records.
 3. Invitation to parent to be present.

Assisting doctor at examination.

Making health service room attractive.

Assisting dentist at dental examinations.

Follow-up of defects.

Arranging for immunization clinics.

Observation of sanitary conditions in school and reporting same.

Recording.

Screening of children for thyroid prevention.

First aid.

Arranging for distribution of free milk.

Selling vitamin pills.

Audiometer testing:

 1. Actual testing.
 2. Selecting cases needing reference to doctor.
 3. Reporting doctor's finding to teacher and parent.
 4. Arranging for attendance at lip-reading classes.

Assisting teacher in proper seating of pupils with vision and hearing defects.

Attendance at, and participation in, Parent Teacher Association meetings.

Interpretation of the function of the public health nurse in the school and the community to the school personnel.

Assisting in the promotion of school lunch programs.
- (b) Home visiting.

Interpretation of school to home.

Interpretation of doctor's findings.

Discussion of general physical, mental and emotional development of the child.

5. Activities in relation to Communicable Disease Control and Prevention

- (a) Acute Communicable Disease.
 1. In school through methods mentioned under 4 above.
 2. Through home visit by teaching parents:
 - (a) Prevention through immunization.
 - (b) Recognition of early signs and symptoms.
 - (c) Isolation.
 - (d) General health principles.
 3. In community by continuous health education.

4. Carrying out immunization procedures in clinics.
5. Taking throat swabs for diphtheria, scarlet fever.

(b) Tuberculosis.

- Education of patient and community regarding prevention, method of spread, treatment.
- Teaching isolation precautions to patient and family.
- Teaching how to take the cure.
- Helping the patient to understand the disease and how to adjust his way of living.
- Giving instructions about concurrent and terminal disinfection.
- Interpreting x-ray and laboratory reports to the patient.
- Arranging for x-ray appointments for case and contacts.
- Giving Mantoux and patch tests.
- Reading these tests.
- Trying to trace source of infection.
- Referring to proper agency for assistance in financial and social problems.
- Assisting with preparation for admission to hospital.
- Interpreting home conditions to medical and nursing personnel at hospital.
- Interpreting patient's progress in hospital to the family.
- Evaluating suitability of home conditions for patient's return.
- Follow-up teaching after discharge from hospital.
- Arranging for and assisting with mass surveys.
- Assisting at regular x-ray clinics.

(c) Venereal Disease.

- Assisting in follow-up cases.
- Assisting in contact finding.
- Health education of individual and community in relation to venereal disease.
- Recognizing need for case work and referral for same.

6. Activities in relation to Mental Hygiene

- Interpreting the principles of mental hygiene, which is the normal mental development of the child, to parents and teacher.
- Helping the teacher to detect mental hygiene problems.
- Interpretation of the problem to the mother and guidance on further examination and treatment.
- Preparing case histories for mental hygiene conference.
- Presenting case history to the group conference.
- Interpreting home and school situations to psychiatrist.
- Follow-up of doctor's recommendations in school and home.
- Supervision in the home of case discharged from mental hospital and reporting on progress.
- Administering intelligence tests.

7. Activities in Relation to Health Education

- Teaching the principles of good health to all age groups.
- Speaking to community groups.
- Organizing conferences on health topics.
- Operating film projector.

8. Activities in Relation to Community Relationships

- Taking part in activities promoting the health and welfare of the community.
- Serving on committees of allied community agencies.
- Interpreting the work of the public health nurse to community groups.

9. Activities in Relation to Supervision

- Supervision of students who may be assigned for field work.
- Planning an adequate program for student field work.
- Writing evaluation reports on students.
- Assisting in the orientation program of new staff workers.
- Selection, training and supervision of volunteers.

10. Activities in Relation to Administration

- Planning the public health nursing program, both long-term and short-term.
- Making time-tables.
- Designing records.
- Setting up filing systems.
- Assignment of duties to clerical workers.
- Giving dictation.
- Driving car.
- Keeping records up to date and following the principles of good recording.
- Taking inventories.
- Ordering supplies.
- Preparation of supplies for sterilization.
- Cleaning equipment and supplies.
- Keeping expense accounts.
- Keeping mileage reports.
- Transportation of patients to hospital or clinic.

11. Activities in Relation to Professional Development

- Participation in staff meetings and conferences.
- Assisting in the planning of in-service training program.
- Maintaining active interest in the nursing profession apart from agency activities.
- Professional reading.

12. Other activities

(a) Industrial:

- Health counselling.
- Assisting with medical examinations.
- Follow-up home visiting.
- Health and safety education.
- First aid.

(b) Nutrition:

- Teaching normal nutrition through child health conferences, home visiting, group conferences, etc.
- Adding new foods to diet of infants.
- Changing infant's formula.

(c) Arranging for homemaker service.

(d) Inspection of boarding homes for children.

(e) Health supervision of kindergartens and nursing schools.

(f) Inspection of nursing homes.

(g) Assisting with summer camp examinations.

(h) Assisting at orthopaedic clinics.

(i) Assisting at eye clinics.

(j) Sanitation.

- Observation of sanitation of environment of schools, homes, etc., and reporting unsatisfactory conditions.
- Taking of water samples.

(k) Social welfare.

- Referral of cases to social worker.
- Doing the job herself to the best of her ability where there is no social worker.

(l) Collection of fees.

APPENDIX B

RELATED PUBLIC HEALTH NURSING AGENCIES AND OTHER SERVICES

A. Visiting Nurse Associations

Throughout this report the terms "official" and "non-official" have been used in relation to health agencies. The term "non-official" refers in most cases to the visiting nurse associations. There are three of these in Canada. The largest is the Victorian Order of Nurses which has 105 branches and approximately 500 nurses in eight provinces. The St. Elizabeth Visiting Nurses' Association has two branches, one in Toronto and one in Hamilton, and approximately twenty nurses. Both of these associations have a bedside nursing and health education program. The third is the nursing service of the Metropolitan Life Insurance Company. There are over seventy nurses in this service, the majority being in the city of Montreal and all but two in the Province of Quebec. Bedside nursing care and a health education program are provided for policy holders.

The working relationships between official health agencies and visiting nurse associations are most important in order to provide an effective health service for the community and to avoid unnecessary overlapping and waste time of personnel.

In general, where there is a branch of a visiting nurse association, the latter is responsible for the bedside nursing service, the pre-natal nursing supervision, and post-natal supervision up to six weeks of its own cases. At this time the infant is referred to the official agency for continued health supervision as required. There were exceptions to this general policy in three urban areas visited. In one, both agencies claimed responsibility for the pre-natal program. In a second, the official agency considered the pre-natal nursing supervision and the conducting of pre-natal classes as its field and the printed policy was that the visiting nurse refer the pre-natal case to the health department for nursing supervision, unless confinement was to take place in the home. In neither of these was there a feeling of good co-operation or a sharing of responsibilities. In the third, both agencies shared in the pre-natal nursing supervision and in the pre-natal classes. In this area nurses of one of the visiting nurse associations took part in health department child health centre activities. The sharing of responsibilities is commendable as it enables the nurse in each agency to have a more varied program, and makes it easier to provide a family health service. It is a step toward the merging of official and non-official public health nursing agencies for a more effective community health service.

An experiment is being conducted in one semi-rural area with the merging of the programs of the official agency and the visiting nurse association, but this has not progressed to the stage where definite statements can be made. Some success has been reported in similar projects in the United States (1), (2).

B. Social Agencies

The efficiency of the public health program is closely related to the extent to which the social welfare program of the community is organized with staffs of qualified social workers. It is impossible to separate the health and social aspects of illness, and no one appreciates this more fully than the public health agency. In one area visited in which tuberculosis was a serious problem, it was estimated that about two-thirds of the time was devoted to welfare activities, such as arranging with the municipal officials for relief for a family, arranging for Mothers' Allowance, etc. In addition, there are many times when it is not quite

so easy to draw the line between public health nursing and social work, and when at least the consultant services of a qualified social worker are essential. Close working relationships of the two professions are facilitated when office accommodation is in the same building. This should be given consideration when plans are being made for changes in health units and for the establishment of new units. The need for a social case worker on the staff of the health agency and as a member of the health team is mentioned on page 73.

C. Canadian Red Cross

As a voluntary agency the Canadian Red Cross Society pioneered in the development of public health nursing in Canada. This started with the subsidizing of special courses in university for the preparation of public health nurses. The responsibility has now been assumed by the universities. The Society helps to meet the health needs of 76 communities through its Outpost Hospitals. Approximately half of these outposts are small emergency units staffed by one or two nurses who carry a generalized public health nursing program, if it is not provided by some other agency. Of a total of 38 qualified public health nurses, 21 serve in the outpost program, and the remainder as directors of Junior Red Cross or nursing services at the national, provincial and large branch levels. The directors of nursing services, as a part of their varied activities, direct the program to utilize the volunteer service of graduate nurses as instructors of lay women in the fundamental principles of the care of the sick in the home. These women in turn frequently volunteer to serve health agencies in their own communities.

D. Visiting Homemaker Services

Of nine urban areas studied, seven had a visiting homemaker service. In three it was operated by the Red Cross*, in two by the Family Welfare Bureau, and in one by another visiting homemaker organization. In nearly all the areas, need was expressed for an extension (or establishment) of the services.

Of ten rural areas studied, two with headquarters in urban centres had visiting homemaker services. Nearly all the rural areas also expressed the need for this service.

This service is a very valuable aid in a public health program. So frequently when the mother is ill in the home or in the hospital, someone is required to look after the children and the housekeeping duties. A trained or practical nurse is not necessary. It is important, however, that the visiting homemaker service be directed and supervised by a professional worker.

Recommendations

1. One or more demonstration areas should be selected for research in the provision of a completely generalized public health nursing program (including bedside care).

2. Public health agencies should encourage the establishment and extension of visiting homemaker services. (This service would be included in the experiment suggested above.)

3. The consultant services of a qualified social case worker should be available for all public health personnel.

References

1. Palmquist, Emil, and Prindiville, Marguerite. It works in Seattle. Am. J. Pub. Health, 1948, 38: 1663.
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*Across Canada more than 30 Red Cross Branches have a Homemaker Service.

APPENDIX C NURSING IN INDUSTRY

It is estimated that approximately 750 nurses are engaged in full-time nursing service in industry in Canada. In addition, 13 branches of the Victorian Order of Nurses supply part-time service to industry.

Three provinces have a division of industrial hygiene, but only two have industrial nursing consultants. One of these is full-time but the other has supervisory duties in the generalized public health nursing field as well.

In the Province of Ontario, which employs a full-time industrial nursing consultant, there are 469 nurses engaged in full-time service in industry and 3 in part-time service. Of these, 37 nurses, or slightly less than 8 per cent, have had public health nursing preparation. Judging from observations made and interviews with nursing leaders in other provinces, it is probable that this proportion applies to the remainder of the full-time industrial nurses in Canada. (This does not apply to the part-time service given by visiting nurse organizations. Whenever possible, these organizations assign a fully qualified public health nurse to the industrial services.)

The Civil Service Health Division of the Department of National Health and Welfare is organizing an industrial service which it is hoped will be extended for their employees across Canada (1). At present this is in the developmental stage in Ottawa. On March 25, 1949, they had 27 nurses of whom 14 were qualified in public health. The 25 staff members are known as "nursing counsellors" and they have a nursing director and supervisor.

The Ontario Division of Industrial Hygiene has recommended the following requirements for industrial nursing services in that province:

"Number of employed, per graduate registered nurse per shift"

Up to 499.....	one
500 to 999.....	two
1,000 to 1,599.....	three
1,600 to 2,299.....	four
2,300 to 3,000.....	five

"For each additional 800 employees on a shift, one additional graduate registered nurse is required."

The Civil Service Health Division, Department of National Health and Welfare, which provides a service to office workers who are subject to few industrial hazards, plans to have a ratio of one nurse to five hundred employees. It has been found from experience that if there are more than five hundred, a satisfactory service cannot be given by one nurse.

One province conducted a study* which included industrial nursing. Replies to a questionnaire sent to 267 industrial plants having full-time nursing service indicated that of the 127 plants reporting, 8 had a full-time medical officer; 69 had part-time medical officers; 41 had a physician on call; 7 had no medical direction; 2 made no statement.

Personal observations were made in 13 industries having nursing service, in three of the provinces. The industries included utility services, manufacturing, bakery, dairy and department store. A total of 54 nurses were employed in addition to the part-time services of three Victorian Order nurses. The number

*A Study Conducted by the Registered Nurses Association of Ontario in April, 1948.

of employees per full-time nurse ranged from 350 to 1,500. Observations were made with both fully qualified public health nurses and with professional nurses without public health preparation. Following are some significant observations:

- (a) In the majority of cases the management provided as good accommodation as was possible and there were excellent working relationships between the health service personnel and management.
- (b) The signs on the doors of the various health services varied: "First Aid", "Medical Service", "Health Service", "Nursing Counsellor".
- (c) Frequently the first contact of the employee with the health service was made for first aid. (Exception: where a pre-employment interview was given. This is a very important contact.)
- (d) Where supervision and consultative service was available and an opportunity given to participate in a good staff education program there was noted a keener interest, a better recognition of the problems, and a more extensive use of community facilities.
- (e) From the limited personal observations made when the nurse was working alone, or where there was no public health nursing direction:
 1. Usually the nurse with public health training had a better knowledge of, and made more extensive use of, community resources.
 2. The public health nurse carried on more extensive nutrition education.
 3. The public health nurse seemed to have a better understanding of the total needs, health and welfare, of the employee and his family.
 4. Generally speaking, the public health nurse made more use of the initial contact of the employee coming for first aid, as an opportunity for establishing a basis for future health counselling, than did the nurse not trained in public health. The latter tended more to confine her service to treatment.
- (f) Many nurses working alone in industry, who have not had public health nursing preparation, but who have had extensive experience, are doing an excellent job.
- (g) In the majority of cases, the nurse has an initial interview with the patient before the medical examination and she takes a considerable part of the history.
- (h) Technical duties the industrial nurse is called upon to perform in connection with the medical examination are usually limited to the taking of blood for Wassermann, checking the hæmoglobin by various simple methods, taking blood pressure, and doing urinalysis.

It has been estimated that in the Province of Ontario over 400 more nurses would be required in manufacturing industries alone to meet the minimum requirements recommended. (This does not include service on a part-time basis to the plants of 250 or fewer employees, of which there are over 1,800.) A safe minimum estimate for the industrial needs for all of Canada would be 1,000 more nurses. It should be pointed out that the management of these industries have not yet indicated their readiness to accept an industrial health service. Nevertheless, this does represent a potential need of professional nursing personnel.

The Facts Show Briefly that:

1. Approximately 750 nurses are engaged in full-time nursing service in industry in Canada.
2. The buying of service by industry from a visiting nurse association is an important development, and there are still many small industries which are potential buyers.
3. In the majority of industries nurses are not required to perform other than nursing duties.

4. The majority of employers make some provision for nurses to attend refresher courses.
5. The majority of employers, although not demanding further qualification than an R.N., give preference to the nurse with further qualifications.
6. Only two provinces have a consultant in industrial nursing. Over 60 per cent of the industrial nurses of Canada are employed in one of these provinces.

Much has been written about the value to both employer and employee of an industrial health service, but to our knowledge, not a great deal of emphasis has been put on the value of such a service to public health generally. In the majority of cases, the employee is the breadwinner. The educational effort of the official health department nurse or the visiting nurse is necessarily directed to mother and children, and the absent member of the household may remain unconvinced. This large group, which could not be so readily contacted through other community health agencies, is reached through the industrial health service in a systematic manner.

The following have been suggested as the duties of nurses in industry.*

1. First-aid care.
2. Assistance with medical examination.
3. Participation in health education program.
4. Assistance with safety education and accident prevention.
5. Participation in welfare activities.
6. Assistance with plant sanitation.
7. Home nursing service.
8. Recording and reporting.

Apart from straight first-aid care, all of these duties require preparation over and above the basic nursing course. In industry often the first contact is made for first-aid and it is here that the public health nurse can interest the employee in his general health. The nurse's assistance with the medical examination frequently includes interviewing the worker previous to the examination. It is during the initial interview that the nurse can establish the rapport on which depends future health counselling. Here she learns not only about his own health, but the health of his family and their needs. The follow-up for correction of remediable conditions is a part of the health education program. This, in almost all cases, involves the use of community resources and the nurse must know these. It includes also the supervision and rehabilitation of workers with health problems. Assistance with safety education and accident prevention requires a knowledge of the methods of health teaching. Assisting with plant sanitation requires more information relating to sanitation than is given in the basic nursing course. For participation in plant welfare activities the nurse must have knowledge of community health and social agencies. She should also have an understanding of social factors and needs to be able to recognize problems which should be referred to social agencies. The planning, or the assistance with the planning, of a cafeteria, lunch room and canteen services is sometimes a duty of the industrial nurse. In this connection a great deal of practical nutrition teaching may be done and she requires a knowledge of this subject.

The home visiting service is largely limited to visiting employees absent because of illness and making investigations for sick benefit where the nurses are required to do this. It is right that the home visiting service should be so limited. This is an important area to watch for over-lapping with other health agencies in the community. The nurse, therefore, needs an understanding of the work of these agencies in order to assure the best co-ordination.

*Ontario Division of Industrial Hygiene.

Recording and reporting in industry are very important as they make it possible for the nurse to work effectively and to interpret to management the value to be obtained from the nursing service. The industrial nurse requires a more thorough understanding of records and reports than she obtains in the basic preparation of the hospital school of nursing.

In briefly analyzing some of the components of the nursing duties, it has been indicated that the nurse employed in industry requires more than basic nursing skills. She probably should have more than the usual public health nursing preparation, but she needs it as a basis on which to build her specialization.

A university in the United States has planned a curriculum of study leading to a Bachelor of Science degree in Nursing with a major in Industrial Nursing. This course includes Sociology, Psychology, Mental Hygiene, Social Work (for interviewing techniques), Methods of Health Teaching, Principles and Practices of Industrial Nursing, Industrial Toxicology, Personnel Administration and Business Economics and Economics of Labour. Most authorities agree that all of these should be included in preparation of the industrial nurse. The first five subjects mentioned are included in almost all Canadian basic public health nursing curricula. Only one university in Canada gives a special course for preparation in industrial nursing. This is taken as an "extra" during the year of public health nursing preparation and includes some consideration of the remaining subjects mentioned above. An additional month of field work is also required. In other university public health nursing programs, industrial nursing may or may not be included as a part of some other lecture course. It has been said that "the nursing counsellor service is looked upon as the true corner stone of a comprehensive industrial health service" (1). If this is so, then the industrial nurse has an important part to play in this area of public health, which is, as yet, relatively undeveloped in Canada.

For the following reasons it would seem to be wiser in Canada not to establish a course leading to a degree or certificate in industrial nursing without the basic public health nursing preparation. This latter should, in any case, include for the benefit of all public health nurses, some introduction to industrial nursing.

- (a) The general preparation in public health nursing permits the nurse a greater choice of employment and she is not limited to one field of work.
- (b) Canada has a relatively large number of smaller industries which could secure part-time service from a health agency. If this field were further developed it would draw on the nurses with public health nursing preparation.
- (c) The basic preparation in public health nursing is a necessary background for the specialty of industrial nursing.

From available information it would appear that the trained practical nurse or certified nursing assistant had not been employed to any extent in industry in Canada. The practical nurse in industry is discussed by Miss Deming in her book, "The Practical Nurse". The following paragraph is quoted:

" registered nurses should be the first nurses employed and practical nurses should be added only when the time arrives for a supervised program of subsidiary nursing duties. In a light, non-hazardous job in a small plant, there may never be a place for a licensed practical nurse, but a busy medical department in a heavy industry employing many unskilled workers can use a licensed practical nurse full-time just as soon as each shift is headed by a professional nurse. Every situation, however, will be a rule unto itself" (2).

Recommendations

Realizing:

1. That an industrial nursing service is an important adjunct to a public health service.
2. That there is a need for the expansion of these services in industry.
3. That two things are necessary—
The education of management to the value of a health service, and more nurses.
4. That for a long time to come the demand cannot be met with qualified public health nurses:

The following recommendations are made:

1. That in those provinces in which there is a sufficient amount of industrial development to indicate need, a division of industrial hygiene of the provincial department of health be established, and that a qualified full-time industrial nursing consultant be appointed.
2. That in those provinces where there are not sufficient industries to justify a division, there be a full- or part-time qualified industrial nursing consultant attached to the division of public health nursing.
3. That in the larger industrial centres the official health department participate actively in the development of industrial health services, and if indicated, employ a full-time qualified industrial nursing consultant to work with the nurses in industry in an advisory capacity and to assist in the development of educational programs.
4. That every industrial health service have a full- or part-time medical director.
5. That small industries with health services:
 - (a) Purchase service from a health agency on a part-time basis, or
 - (b) Group together to secure a full-time nurse if service from a health agency is not available.
6. That where an industry employs only one nurse, she be a fully qualified public health nurse.
7. That where more than one nurse is employed, at least the nurse in charge be qualified in public health nursing.
8. That the nurse employed by industry, whether qualified in public health nursing or not, should have at least a year and preferably more of nursing experience beyond the basic nursing preparation in a hospital nursing school.
9. That universities:
 - (a) Include some industrial nursing in the public health nursing course.
 - (b) Provide additional lectures and field work for those taking the public health nursing course who are especially interested in industrial nursing.
 - (c) Promote, in co-operation with the provincial or urban industrial nursing consultants, educational programs for those already engaged in industrial nursing.
10. That the professional qualification for industrial nursing be the basic preparation in public health nursing with additional theory and practice in the special area.
11. That in their professional organizations, industrial nurses take an active part in the public health nursing sections.

References

1. Report of the Civil Service Health Division of the Department of National Health and Welfare for the fiscal year ending March 31, 1948.
2. Deming, Dorothy: *The Practical Nurse*. The Commonwealth Fund, 1947, p. 158.

APPENDIX D

THE PUBLIC HEALTH NURSE IN THE HOSPITAL

The purpose for which observations were made and interviews held was to try to find out:—

1. How public health nurses are used in service to patients in hospital either as members of the hospital staff, or members of a community health agency staff.
2. The relationship between the public health nurse and medical social worker,* functioning in the hospital setting.

The following descriptions of the practice in six large centres are based on personal observations and interviews. They do not, by any means, present a complete picture and in some cases, observations were not as lengthy as in others. They do point out a great diversity of practice.

Centre "A"

In one of the hospitals in this city a nurse from the staff of the health department acts as liaison between the hospital and her department. She has an office in the out-patient department of the hospital, and the door of her office is marked "Social Service". She interviews all new patients and re-admissions, and directs them to the appropriate clinic. This takes so much of her time that there is little left to interview the patient after he has been seen by the doctor and before he leaves the clinic. The nursing service of the out-patient department is directed by a public health nurse appointed by the hospital.

In another hospital in the same city the "Hospital Social Service" staff consists of nurses. The nurse in charge is public health trained and when possible, she selects nurses with public health training for her staff. At the time of observation they were not so qualified. All new patients are interviewed in this department and, when indicated, cases are referred to community health social agencies.

Centre "B"

In one hospital visited there is a social service department staffed by trained medical social workers. The nursing service of the out-patient department of this hospital is directed by a public health nurse and preference is given to public health nurses for staff. From this department there is a direct referral system to community health agencies. Social problems are referred to the social service department, which also has direct contact with the community health and social agencies.

Centre "C"

A public health nurse employed by the health department is in charge of the admitting section of the venereal disease clinic at one of the hospitals and she is known as the "social service nurse". She is also responsible for the follow-up of venereal disease cases and contacts in the district. There are also two nurses, neither trained in public health nor social work, employed by the auxiliary of the hospital to assist in planning patients' discharge and the purchasing of appliances. These nurses are referred to as "social service" nurses.

*The term medical social worker is used here in reference to the professionally prepared social worker with training and/or experience in the application of social case work to the medical setting. In Canada two schools of social work have offered the specialty in medical social work.

Centre "D"

In one hospital the social service department is directed by a worker who is qualified in both public health and medical social work. She has on her staff one medical social worker and several public health nurses. The former interviews only cases referred to her by the doctor and the nurse in the medical clinic to which she is assigned while the others see the majority of cases in their particular clinics. Referrals are made from this department to the community health agencies.

In each of several other hospitals there is a department known as the "Hospital Health Service". The professional personnel of this department are public health nurses who are on the staff of the health department. The stated objectives of the hospital service nurse is:

1. On behalf of the patient she acts as a co-ordinator between home, hospital and interested agencies by—

(a) Assembling for the physician all factors bearing on the case, such as home conditions, type of care patient will receive on discharge, etc.

(b) Translating to the community workers the physician's orders for treatment and management of the patient in the home.

2. Health teaching and interpretation of physician's orders to the patient or member of the family.

3. Assistance in dealing with problems and difficulties of patients including mental adjustment to illness, and detection and referral of social problems.

There are no social service departments in those hospitals in which the hospital health service functions. (Exception: a D.V.A. hospital to which a hospital health service nurse has recently been assigned.)

Centre "E"

In five hospitals in this city there are social service departments, all of which are directed by medical social workers. The staff members are all trained in medical social work, with the exception of one hospital in which some who have had no formal training, have had many years of experience. The personnel of these departments see patients only on referral and community health and social agencies are contacted by them. Two of the out-patient departments are directed by public health nurses.

Centre "F"

A public health nurse from the visiting nurse agency is responsible for the nursing administration of a pre-natal clinic within an out-patient department. This occupies one afternoon a week. The nurse does not have time to interview the patients, but she makes a list of those attending so that the agency may follow-up in the home.

These examples show:—

1. That there is a confusion in the use of the term "social service".

2. That not all large hospitals have social service departments.

3. That some hospitals have "social service" departments without any qualified social service personnel.

4. That public health nurses are functioning within the hospital either:

(a) As full-time or part-time while on the staff of a community health agency, or

(b) As members of the hospital staff.

5. That referrals are made directly to the community agency either by the member of the agency or the hospital staff.

6. That in some cases the medical social worker is functioning alongside the nurse and the public health nurse in the hospital.

7. That where qualified social workers are used within the hospital, these workers do not make the admission interview; the accepted procedure is that they will interview only cases which have been referred to them by the doctor and/or the nurse who have recognized a special problem requiring the service of a qualified social worker.

Following are observations made during visits with some of the members of the services in the centres mentioned above. These observations were confined to workers who were employed by a community health agency rather than by the hospital.

1. In an eye clinic the public health nurse was checking the financial arrangements for obtaining glasses.

2. In making visits on the obstetrical ward (this was a follow-through from the pre-natal clinic), the nurses discussed breast feeding with several of the mothers and urged them to return to the clinic for a post-natal examination.

3. In a tuberculosis clinic the nurse was giving appointment slips to go to another part of the hospital for x-ray.

4. In a pre-natal clinic the nurse was giving return appointments. (The function of this nurse was to conduct a teaching interview, but the chief emphasis during the period of observation was on the making of return appointments.)

5. The nurse was taking all the admission histories.

6. The nurse was giving return appointments at a diabetic clinic. (Her function was teaching and the clarification of any problems the patient might have. However, there were so many patients, with no privacy for interviewing, that here again the giving of return appointments seemed to be receiving the chief emphasis.)

7. The nurses were doing a great deal of clerical work because of lack of clerical assistance. One nurse stated that half her time was taken by clerical work.

8. The nurse was interviewing patients,

(a) To determine whether they were eligible for clinic care.

(b) To determine to which clinic they should be referred.

(c) To explain clinic charges, etc.

9. The nurse was getting patients ready for the doctor.

10. Many public health nurses indicated, by their response to questions, that their interpretation of social work was the arrangement for material relief. They did not appear to have an adequate concept of social case work and the need of it.

Comment

It would appear that the whole question of the function and place of the public health nurse in the hospital should be studied with the following questions in mind:

1. Is the patient receiving the greatest benefit possible from existing services?

2. Are qualified public health nursing personnel being wasted through:

(a) Overlapping of service?

(b) Lack of clerical service?

(c) Lack of proper delegation of duties among all personnel and of the out-patient department in particular?

3. Are we removing opportunities and responsibilities from the hospital personnel which are rightfully theirs? If we take from the hospital nurse the responsibility for health teaching and for direct referral to the community health agency, are we not defeating our purpose and desire to make the hospital nurse more aware of community resources, and more aware of the teaching aspect of her function as a bedside nurse?

4. Are we missing some real "social" problems?

In illness there are three main aspects: the medical, the nursing and the social. It is gradually being recognized that the medical social worker is a member of the "health team" in hospital and public health work.

A stated function of one public health nursing group is "assistance in dealing with problems and difficulties of patients including mental adjustment to illness, and detection and referral of social problems" (page 72, Centre "D").

It is considered that the public health nurse should have enough knowledge of social work to be able to detect social problems and enough knowledge of community social agencies to make proper referral. That all public health nurses have this knowledge is questionable. This deficiency can best be overcome through the public health nursing courses, through in-service education, and by the close working relationship of the medical social worker and the public health nurse. Some of the social problems of the patient in hospital or clinic may be handled by a community agency, but there will still be social problems relating to the illness of the patient which require a medical social worker in the hospital who works in close association with the medical staff. The early detection of these problems is the responsibility of the doctor and the nurse.

Mention has been made above of the medical social worker in public health. From available information, there are only two health agencies in Canada which have qualified social workers on their staff. One is a very recent appointment and the other is in a developmental program where the functions of all personnel are being formulated. These two workers are pioneers for their profession in Canada.

Recommendations

1. That public health nurses, hospital nurses, and medical social workers together study their respective functions and relationships in the hospital.

2. That public health nurses and medical social workers together study their respective functions and relationships in the public health program of the community.

3. That, as a first step, a job analysis be made in each hospital in which there is a public health nurse employed by a community health agency, to determine which duties she should do and which should be done by:—

- A clerk.
- A hospital staff nurse.
- The social worker.
- The public health nurse in the district.

4. That in each hospital an in-service training program with out-patient department and other hospital staff be established to incorporate health teaching and acquaint the staff with community health and social agencies.

5. That the director of the nursing service of the out-patient department of the hospital be a qualified and experienced public health nurse, and further that, depending on the clinical services, some of the out-patient department staff nurses be qualified in public health nursing.

APPENDIX E PREPARATION OF NURSES EMPLOYED BY OFFICIAL AND NON-OFFICIAL PUBLIC HEALTH AGENCIES

Province	No. Nurses Employed			Preparation-Percentage					
				Public Health Nursing			No Public Health Nursing		
	Official	Non-official	Total (1)	Official	Non-official	Total	Official	Non-official	Total
British Columbia	182	46	228	96.1	84.8	93.9	3.9	15.2	6.1
Alberta	75	9	84	56.0	77.7	58.3	44.0	22.2	41.7
Saskatchewan	79	7	86	36.7	85.7	40.7	63.3	14.3	59.3
Manitoba	105	19	124	56.2	63.2	57.3	43.8	36.8	42.7
Ontario	658	308	966	83.7	72.7	80.2	16.3	27.3	19.8
Quebec	424	127	551 (2)	18.0	33.9	21.6	82.0	66.1	78.4
New Brunswick	17	19	36	64.7	63.2	63.9	35.3	36.8	36.1
Nova Scotia	53	42	95	62.3	50.0	56.8	37.7	50.0	43.2
Prince Edward Island	8	0	8	62.5	0	62.5	37.5	0	37.5
Total	1,601	577	2,178	61.3	63.1	61.8	38.7	36.9	38.2

(1) Figures include those given by provincial directors of nursing plus the directors of nursing of urban centres, statistics from the National Office of the Victorian Order of Nurses, Metropolitan Life Insurance Nursing Services and St. Elizabeth Visiting Nurse Associations.

(2) This total is not inclusive of the many non-official agencies in Quebec other than those mentioned in (1).

APPENDIX F

PERCENTAGE OF PUBLIC HEALTH NURSING TIME ALLOTTED TO VARIOUS ACTIVITIES

	School	Child Welfare	Tuberculosis	Home Visiting	Miscellaneous (1)
1. Urban Areas					
A	51.2(2)	23.4(2)	14.6(2)	—	10.6
B	38(3)	12(4)	—	24.0	26.0
C	29.3(3)	23.8(5)	—	18.9	28.0
D	42.3(3)	7.9(4)	—	20.8	29.0
2. Rural Areas					
E	32.0(3)	7(4)	—	19.1	41.9
F	30(3)	14(5)	—	27.0	29.0
G	10(3)	11.1(5)	—	25.2	53.7
H	23.9(3)	19.1	—	8.9	48.1

- (1) Miscellaneous covers such items as office time, travel and other activities, except in Area A, where travel and office time, insofar as possible, is allotted to the particular service.
 (2) Includes the home visiting and travel time for these services.
 (3) In school building only.
 (4) Child health centre only.
 (5) Includes clinics such as tuberculosis and pre-natal as well as child health centre.

APPENDIX G HOME VISITS MADE BY PUBLIC HEALTH NURSES

Percentage of total home visits according to various services—Official Agencies 1947

Province	Pre-natal		Post-natal and Infant		Pre-School		School		Tuberculosis		Venereal Disease		All Others	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
British Columbia	0.5(1)	1.7	29.4	49.2	—(4)	11.9	29.8	12.3	37.1	11.4	1.0	—(8)	2.2	13.5
Alberta	0(1)	0	68.8(3)	50.6	—(4)	1.6	31.2(3)	31.6	—(5)	16.2	—(5)	—(9)	0	0
Saskatchewan	0(1)	1.8	29.5	4.5	17.1	6.8	39.5	26.4	8.0	1.5	5.0	2.2	0.9	46.8
Manitoba	3.2	8.0	40.0	50.9	21.4	9.6	15.2	10.1	4.1	9.9	—(5)	1.3	16.1	10.2
Ontario, 1	5.2(2)	4.1	20.3	31.3	30.5	22.2	34.9	23.6	8.5	1.8	0.6	0.5	0	16.5
Ontario, 2	5.7(2)	12.7	33.8	40.3	11.5	—(4)	17.0	22.7	10.9	10.4	1.7	1.4	19.4	12.5
Quebec	2.6(2)	3.9	14.0	41.9	13.3	51.6	23.6	0.5	3.5	2.1	0	0	43.0	0
New Brunswick(6)	0(1)	—(7)	60.4	18.0	26.4	—(4)	13.2	20.4	—(5)	11.8	—(5)	—(8)	0	49.8
Nova Scotia	0(1)	2.2	30.6	6.9	—(4)	8.2	38.4	11.4	23.3	58.0	—(5)	5.4	7.7	7.9
Prince Edward Island	*	1.3	*	7.0	*	12.9	*	30.3	*	34.2	*	4.5	*	9.8
CANADA	3.4	3.0	25.7	21.2	14.3	11.5	23.5	17.1	9.2	28.1	0.7	2.8	23.2	16.3

- (1) Service carried by a visiting nurse association.
 (2) Service carried by both official agency and visiting nurse associations.
 (3) Child welfare services and school services are specialized.
 (4) Included with infant visits.
 (5) Special workers.
 (6) From statistics for provincial service—no separate figures for areas visited.
 (7) Not reported.
 (8) Not reported separately, included in all others.
 (9) Special service
 * Included as a rural service only.

APPENDIX H

ACUTE COMMUNICABLE DISEASE IN SCHOOL CHILDREN

Area	Exclusion from and Re-admission to School*	Visits by Health Dept. Personnel	Placardable Diseases Placarded and Released by:
URBAN			
A	Nurse	Nurse—selective	Quarantine Officer
B	Nurse	Nurse—tries to visit all	Quarantine Officer
C	Nurse	Quarantine Officer Not visited by nurse	Quarantine Officer
D	Nurse	Nurse—all major, selective for minor	Quarantine Officer
E	Nurse	M.O.H.	Quarantine Officer
F	Nurse	Nurse and Quar. Officer —all cases	Quarantine Officer
G	Nurse	Nurse—all cases twice	Nurse
H	Teacher	Not visited	Quarantine Officer
I	Nurse	Nurse—all cases twice	Quarantine Officer
RURAL			
A	Nurse	Nurse—selective	Nurse
B	Teacher	Nurse—selective	Nurse
C	Teacher	Nurse—selective	Nurse
D	Teacher	Nurse—all reported cases	Nurse or Sanitary Insp.
E	Teacher	Nurse—all major, selective for minor	Sanitary Insp.
F	Teacher	Nurse—all major, selective for minor	Sanitary Insp.
G	Teacher	Not necessarily visited	Sanitary Insp.
H	Teacher	Not necessarily visited	Nurse
I	Teacher	Nurse visits only on request of private doctor	Nurse
J	Teacher	Not necessarily visited	Nurse

*The worker listed is the one who generally excludes. If the nurse is not available, the teacher would exclude if the child is obviously ill.